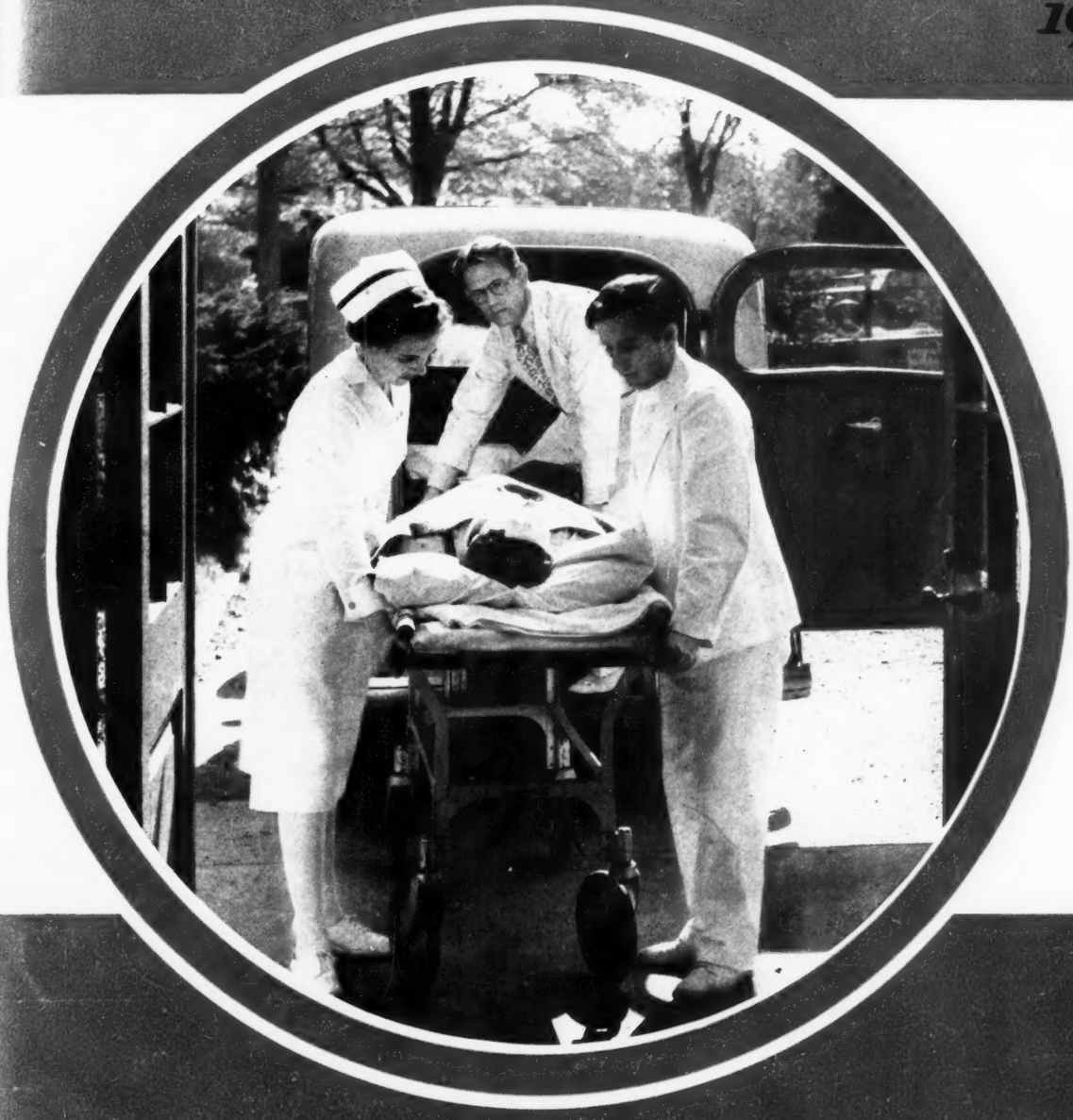
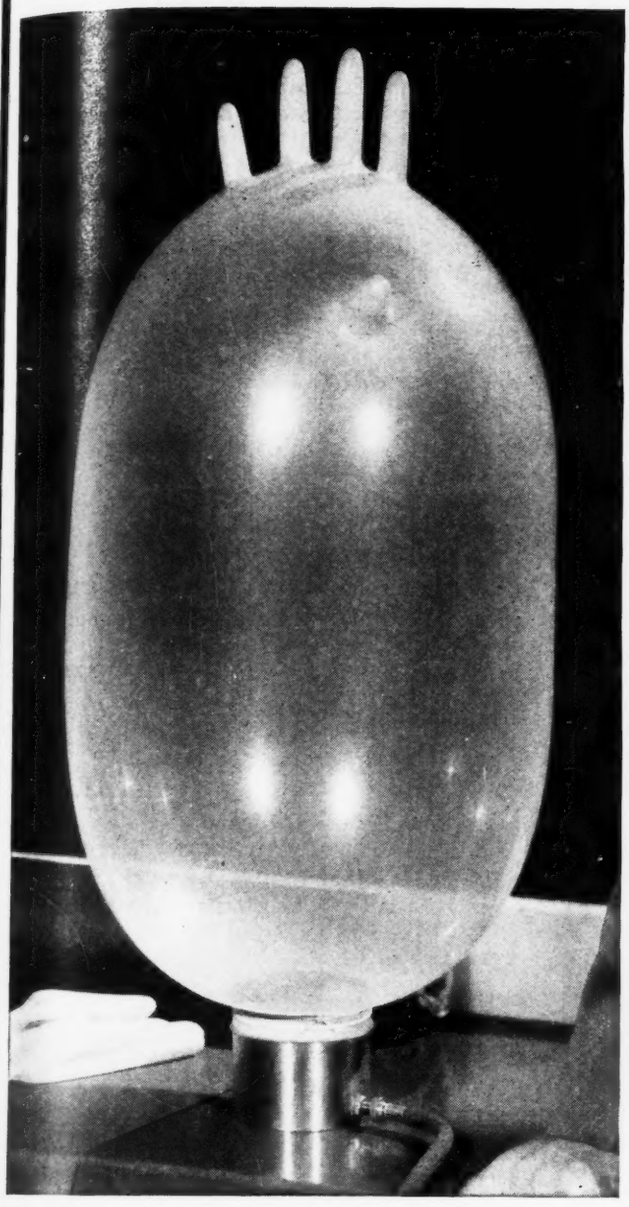
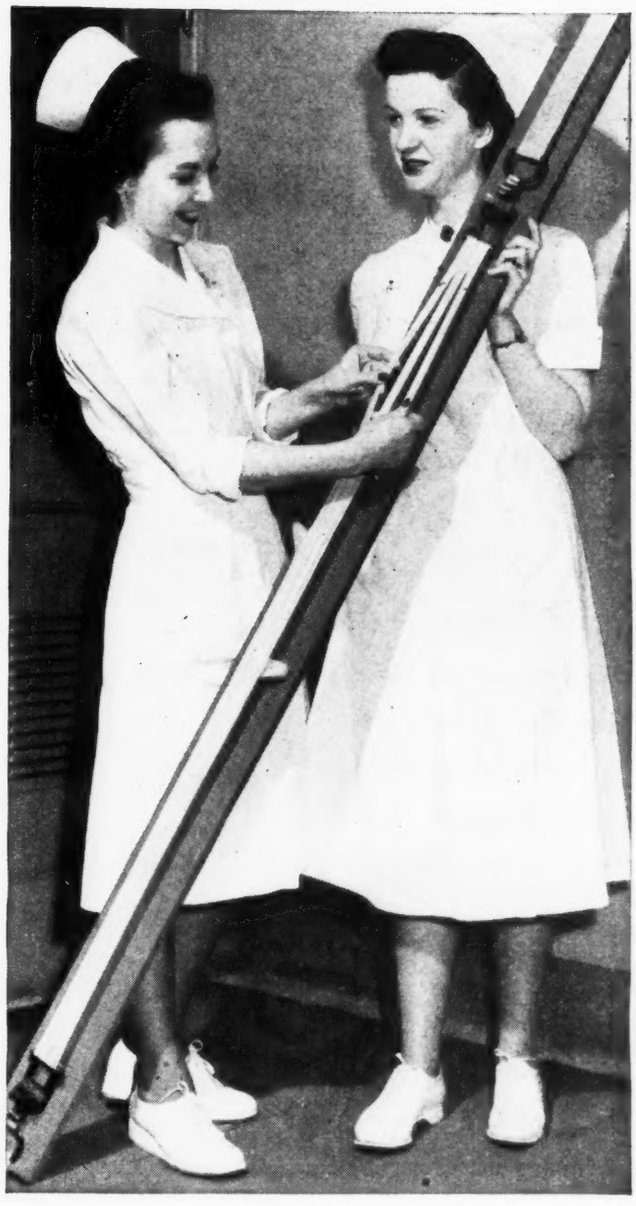
June
VOLUME 70
NUMBER 6
1948

- A European Architect Looks at American Hospitals
- Hospitals' Responsibility for Alcoholics
- Ambulance Service Is a Community Project



The Modern Hospital





No matter how you stretch it, this rubber can take punishment!

A typical example of B. F. Goodrich development in rubber

At the left you see a B. F. Goodrich "Miller" brand surgeon's glove inflated with air, forced in under pressure. At the right you see its mate stretched out 5 feet long. The rubber is a special new compound developed by B. F. Goodrich.

Hospital tests show that even after 15 sterilizations, tensile strength is 2420 pounds per square inch, or more than 1000 pounds over the danger line—a good, conservative margin of safety.

Despite their unusual strength, B. F. Goodrich "Miller" brand gloves are tissue thin, affording the surgeon almost barehand sensitivity and comfort. They are scientifically designed to permit flexing without finger-tip tension. They are constructed with an extra fullness at the back where your own skin is extra full. This allows maximum comfort, reduces operating fatigue.

They are made by the patented Anode process whereby the latex is deposited on the glove form without losing any of its original strength. They are uniformly strong everywhere—even between the fingers, where many gloves are weak. There are no heavy ends at finger tips, no weakening foreign particles in the rubber or between layers of rubber—because they're all *one layer*, again due to the Anode process.

Usage tests prove B. F. Goodrich "Miller" brand surgeons' gloves are the most economical to use. Actual cost per operation averages only 1½ cents. *The B. F. Goodrich Company, Sundries Division, Akron, Ohio.*

B.F.Goodrich
FIRST IN RUBBER

THE MODERN HOSPITAL

LUX IN LITTERIS

OTHO F. BALL, M.D., *President*
RAYMOND P. SLOAN, *Editor*
ROBERT M. CUNNINGHAM JR., *Managing Editor*
E. W. JONES, *Technical Adviser*
MILDRED WHITCOMB, *Associate Managing Editor*
JANE BARTON, *Assistant Editor*
ALDEN B. MILLS, *Western Editor*

In this issue:

Cover . . . . . Norwalk Hospital, Norwalk, Conn.
Photograph by WILLIAM RITTASE

Administration

Trustee Forum

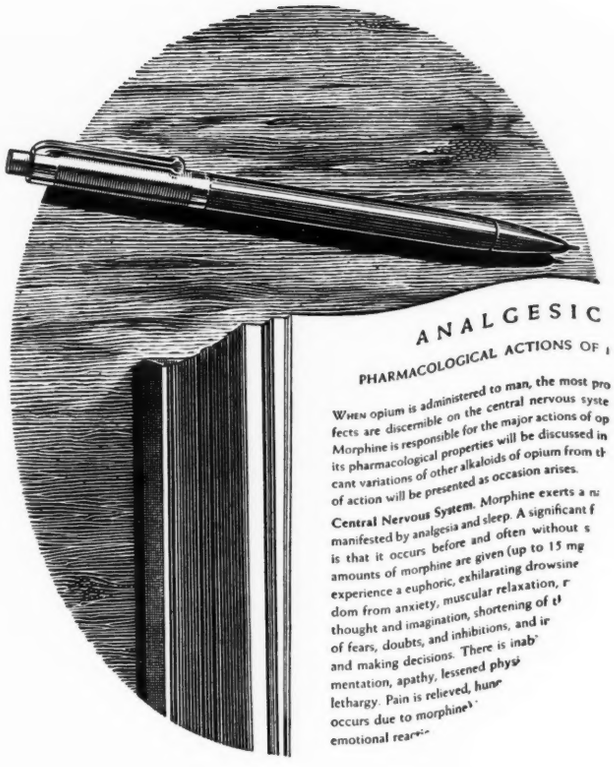
Medicine and Pharmacy

Food and Food Service

Plant Operation

Regular Features

Published monthly and copyrighted, 1948, The Modern Hospital Publishing Company, Inc., 919 North Michigan Avenue, Chicago 11, Ill., U. S. A. (Cable Address: Modital, Chicago.) Otho F. Ball, president; Raymond P. Sloan, vice president; Everett W. Jones, vice president; Stanley R. Clague, secretary; James G. Jarrett, treasurer. North and South America, $3 a year; foreign, $4. Single copies; current, 35c; back, 50c to $1. Entered as second-class matter Oct. 1, 1918, at the post office at Chicago, Ill., under act of March 3, 1879. Printed in U. S. A.



ANALGESIC

PHARMACOLOGICAL ACTIONS OF

When opium is administered to man, the most pro
fects are discernible on the central nervous syste
Morphine is responsible for the major actions of op
its pharmacological properties will be discussed in
cant variations of other alkaloids of opium from th
of action will be presented as occasion arises.

Central Nervous System. Morphine exerts a n
manifested by analgesia and sleep. A significant f
is that it occurs before and often without s
amounts of morphine are given (up to 15 mg
experience a euphoric, exhilarating drowsine
dom from anxiety, muscular relaxation, r
thought and imagination, shortening of t
of fears, doubts, and inhibitions, and ir
and making decisions. There is inab
mentation, apathy, lessened phys
lethargy. Pain is relieved, hunc
occurs due to morphine's
emotional reac

A NEW CHAPTER IN ANALGESICS

For more than a hundred years, morphine has had no peer in relieving pain; its usefulness as an analgesic overshadowed its unfavorable aspects. In 'Dolophine Hydrochloride' (Methadon Hydrochloride, Lilly), physicians now have another remarkable pain-relieving drug which is effective both orally and hypodermically.

Under many circumstances, 'Dolophine Hydrochloride' is equal to or actually excels morphine in therapeutic effectiveness. Clinically, 10 mg. of 'Dolophine Hydrochloride' provide the same degree of analgesia as that obtained with 15 mg. of morphine, but with less euphoria and sedation. The ability of 'Dolophine Hydrochloride' to relieve spasm of the urinary bladder and to depress the cough reflex is especially noteworthy.
On narcotic orders, 'Dolophine Hydrochloride' is available as:

Ampoules 'Dolophine Hydrochloride,' 5 mg., 1 cc. (No. 454)
Ampoules 'Dolophine Hydrochloride,' 10 mg., 1 cc. (No. 456)
Ampoules 'Dolophine Hydrochloride,' 10 mg. per cc., 20 cc. (No. 435)
Tablets 'Dolophine Hydrochloride,' 2.5 mg. (No. 1711)
Tablets 'Dolophine Hydrochloride,' 5 mg. (No. 1712)
Tablets 'Dolophine Hydrochloride,' 7.5 mg. (No. 1713)
Tablets 'Dolophine Hydrochloride,' 10 mg. (No. 1730)
Syrup 'Dolophine Hydrochloride,' 10 mg. per 30 cc. (No. 116)

To be used only under the direction of the physician.

DOLOPHINE HYDROCHLORIDE

Lilly

ELI LILLY AND COMPANY
INDIANAPOLIS 6, INDIANA, U. S. A.

AMONG THE AUTHORS

Gustaf Birch-Lindgren has designed many of the outstanding hospitals and medical centers in Sweden during his twenty-five years of architectural practice. A graduate of the Royal Institute of Technology and Royal Academy of Art in Stockholm, he has made many trips to the United States and has made studies of hospitals and hospital design problems all over the world.

Helen R. Cahill is chief of the dietetic section of the Veterans Administration regional office at San Francisco, an area which includes 9700 beds in twelve V.A. hospitals, and a staff of eighty dietitians. Miss Cahill is a graduate of Iowa State College and Illinois Institute of Technology. She served her dietetic internship at Michael Reese Hospital, Chicago.

Nelson O. Lindley is serving an administrative internship under Dr. Charles Wilinsky at Beth Israel Hospital, Boston. As a lieutenant in the medical administrative corps during the war Mr. Lindley served as supply officer for several hospital units in the European theater. He is a graduate of Bowdoin College and the Columbia University course in hospital administration.

Florence C. Kempf is assistant director of nursing at the University Hospitals, Cleveland. A graduate of Ohio State University and the Lakeside Hospital School of Nursing, she has been active in nursing education for more than twenty years and is co-author of the book, "Psychology Applied to Nursing." Miss Kempf has held many offices in state and national nursing groups.

A. W. Eckert is administrator of the Fitkin Memorial Hospital at Neptune, N. J., a position he has held since 1938. Prior to that time he served for a year as assistant superintendent. During the war, Mr. Eckert was a major in the medical administrative corps and was director of the dietetic division at Fitzsimons General Hospital, Denver.

Florence M. Gipe is a graduate nurse with degrees in business administration and educational research. At present, she is director of the University of Maryland School of Nursing, where she directs experimental studies in clinical nursing technics. Miss Gipe has been director of nursing education and nursing service at several Pennsylvania and Maryland hospitals and has also been a hospital administrator.

Charles S. Billings is executive secretary of the Kansas State Hospital Association and hospital administrative consultant to the State Board of Health. He is a graduate of the course in hospital administration at the University of Chicago. Mr. Billings entered the hospital field as administrator of Christ's Hospital, Topeka; his previous experience was in credit and collections in business.

Roving Reporter

Behind the Lockers

There is a story behind those new lockers at Miami Valley Hospital, Dayton, Ohio. Round almost any corner, and you may come upon a battery of these lockers for they are fitted neatly into some fairly unlikely spots.

A while back only about one-third of the employes had lockers, the excuse being that there was no place to put more units. And in this case it wasn't exactly love that found a way. Rather, resentment led to the improvement.

Among gifts to the institution was $2000 from the Arkadia Foundation of Rike-Kumler, a Dayton concern, to be used for an employe opinion survey. It was hard for the hospital to get and to keep good employes, and apparently it was not a case of subnormal wages and salaries. (In 1947 this hospital's pay roll was more than a third higher than the entire cost of operation in 1941.)

A firm was employed to make the personnel survey, which was achieved by means of a secret, unsigned questionnaire. Each employe was promised that no one connected with the hospital was ever to see his completed questionnaire; the results were to be computed by the organization making the survey and to be given to the hospital in percentages.

In the section in which employes could voice their criticisms there was overwhelming resentment over the lack of rest rooms and locker space. Those who had no lockers were unhappy, and those who had to share lockers with two or three others were scarcely less affronted. Most everyone found fault with the failure to provide rest rooms.

It has cost the hospital $10,000 to install these conveniences, but L. H. Ringelspaugh, the director, believes they will pay off.

A recent photograph in a restaurant magazine may interest Mr. Ringelspaugh and other administrators. In it, a short in-training session of kitchen help is going on. While the discussion proceeds, the girls have been permitted to slip off their shoes and rest their weary feet. A physiologist might not concede that activity in the brain is stimulated by exposure of the other extremity, but a psychologist probably would.

Girlish Figures

Supt. Nellie G. Brown of Ball Memorial Hospital, Muncie, Ind., has been scanning the vital statistics in her county, and she contends that eighteen years ago there was a big slump in babies.

The low birth rate of 1930, Miss Brown declares, is a primary cause of the current shortage of nurses.

Muncie, Ind., for a number of years enjoyed the prestige of being Middletown, U.S.A., so what Miss Brown finds may carry extra weight.

By 1948 Middletown has moved considerably westward but, nationally, the picture is going to be graver for nurse recruitment in the next few years than it is today, if Miss Brown's theory is correct.

The lowest point in our recorded national birth rate was in 1933. From 1933 to 1940, the birth rate increased only 8 per cent, whereas from 1940 to 1947 it rose 45 per cent. This could mean that the recruitment situation is going to get tighter before it gets brighter.

The lean years for recruitment of student nurses thus would be from 1951 to 1958, if the number of prospects is the criterion.

Supt. Charles V. Wynne of Waterbury Hospital, Waterbury, Conn., also puts the low birth rate of 18 years ago at the top of his list of reasons for the nurse shortage. Other factors he mentions are: more people getting sick, an increased population (more than 200,000 in Connecticut since last census), high marriage rate, shorter hours on duty, and termination of the cadet corps.

Fecundity Figures

What of the bassinet brigade in 1948?

It will be slightly below the full strength of 1947, preliminary data from the Metropolitan Life Insurance Company show. Last year's 27.1 per thousand

Amazingly STRONG

Wear-Ever Chairs in the Triangle Restaurant, Chicago

Teetering this chair 100,000 times didn't faze it one bit

A 200 lb. load was placed on a Wear-Ever Chair which was then rocked mechanically 100,000 times with a 4½" drop on each "rock." At the end of the test it was still rigid and tight.

Wear-Ever Chairs stand up under hard, everyday use. They're light to handle. And so graceful and smart-looking they can be used anywhere.

Silvery, Alumilite finish can't chip, peel, crack or warp; won't show fingermarks. Heavy, washable, non-fading fabrics in red, blue, green, white, brown, dark green. See your supply house or mail the coupon. The Aluminum Cooking Utensil Company, 705 Wear-Ever Building, New Kensington, Pa.

SEE THE NEW WEAR-EVER TABLE

Heavy, thick, warp-resistant top. Covered with formica on top (c.p.) and bottom. Practically any color. Anodized aluminum trim and pedestal, black crackle finish, cast iron base. Square, oblong, and round styles in all sizes.

WEAR-EVER ALUMINUM TRADE MARK REG. U.S. PAT. OFF.

WEAR·EVER *Aluminum Chairs*

We'd like to see your Wear-Ever aluminum chairs and tables:

Color CHAIR ☐..... TABLE ☐..... Price on (quantity) CHAIRS ☐..... TABLES ☐.....

NAME..... TITLE.....

FIRM.....

ADDRESS.....

CITY..... ZONE..... STATE.....

is the highest birth rate in the United States in a generation, company statistics reveal.

Provisional figures for the first two months of the current year issued by the National Office of Vital Statistics show a decrease of 12 per cent from the corresponding figure of last year, but the number of births for January and February is still about one-third higher than the total for the same months in 1946. The prospects are that 1948, therefore, will show the second highest number of births in our history.

The steady increase in births since the 1933 low is attributed to favorable economic conditions and to special psychological factors that were engendered by the war.

The Pacific and Mountain states lead the newborn census figures.

A Model Mental Hospital

A *Stars and Stripes* reporter, Werner Prym, recently visited Germany's largest mental disease hospital, Eglfing-Haar, located 10 miles east of Munich.

Overcrowded, short of equipment, and lacking necessary drugs, nevertheless Eglfing-Haar is called a "model institution" by Military Government's public health branch.

No increase in mental disease resulting directly from the war has been noted by Dr. Anton von Braunmühl, head of the hospital and professor of psychiatry at the University of Munich. He has not seen or heard of any "general neurotic or psychotic reaction following the removal of the Nazis after the defeat of Germany."

Reporter Prym asked the medical director if he believed the charge that postwar Germany is suffering from a "mass dementia praecox." Dr. Braunmühl replied: "External influences naturally are likely to cause manifestations of imbalance among whole nations. This certainly has been established by every sober observer not only in Germany but all over the world.

"However, Germany as a nation is not suffering from a mass dementia praecox but from hunger.

"The 'Nazi superman complex' as a form of neurotic assertion of will over other peoples is widely dispersed. It can be said for all time and all nations that every political power leads to misuse, but every absolute power results in ruin."

Dr. Braunmühl gets the best results in schizophrenic patients with a combination of insulin and electric shock treatments.

"The problem we face now," he told the *Stars and Stripes* reporter, "is the scarcity of insulin. Relatives and friends of patients who live in the States and other countries on a sound economic basis often help out, but in order to give systematic treatment we need regular amounts."

Precautionary Note

Formal invitations by which friends of Mount Sinai Hospital, Chicago, were informed of the preview on May 23 of the new hospital wing carried a footnote reading: "No solicitation of funds." Certainly the insertion of this reassuring phrase did not lessen the number of visitors who attended the open house, toured the new addition, and ate the delicious refreshments. The printed invitations were issued in the name of the board of directors and the woman's board and auxiliaries.

READER OPINION

Practical Nurse's Job

Sirs:

With the great increase in our general hospital population of elderly patients, finding the type of nurse most suitable to work in the field of geriatrics has become a major problem in the nursing service of today's hospitals.

Who is best fitted to adjust herself to this type of nursing day after day, month after month? Not the student nurse, for she must get her experience in the skilled nursing procedures, and after a week or so of the routine care required by aged patients, little is learned in the repetitive grind.

The graduate with her three years of specialized education—the graduate whom we insisted on taking into training, if possible, from the upper quarter of her high school class? Why would anyone with a fairly good intellect and three years of training for a profession want to spend her time feeding and caring for these patients?

Who, then? It would seem that a conscientious, well trained attendant—a kindly, cheerful, honest plodder would be best fitted for these laborious and irksome tasks. In general hospitals, where the average age of the patients grows higher year by year, it seems advisable to have nurse's aides or practical nurses, plenty of them, to perform this not too highly skilled work, thus freeing graduates for nursing that requires more technical skill and knowledge and supervisory experience, and the students to pursue a systematic course of experience in more varied activities.

Cleansing false or decayed teeth, and spoon feeding shriveled mouths aren't very attractive or stimulating jobs. Does the nurse require three years packed with theory and experience to be efficient and meticulous in this work?

Elizabeth Brown, R.N.
Honolulu, T.H.

Moving Day

Sirs:

The move into our new building which took place over Easter week end really went much better than our fondest hopes. Everything had been planned carefully and went according to schedule. As the *Hartford Times* called it, "The Easter Parade" was quite a sight, and no patient suffered from the move. We have been on our "shakedown cruise" ever since.

The move was handled almost entirely by our own personnel and volunteers, including trucks and helpers furnished by industry.

Wilmar M. Allen, M.D
Hartford Hospital
Hartford, Conn.

"Our Hospital" Column

Sirs:

We're trying something a little different in public relations at our hospital, and it is proving successful enough so that we thought others in situations similar to ours might be interested.

Northern Westchester Hospital is a very aptly named hospital. Situated in the village of Mount Kisco (population 6000), it is a community hospital of 100 beds (soon 150), with about 80 per cent of the patients coming from outside Mount Kisco itself, from communities like Chappaqua, Pleasantville, Bedford Village and others. Rivalry and competition are pretty sharp among these communities, and the one thing they have really been able to unite on has been the hospital. So a big part of our public relations program has been to keep that support.

Fortunately, the editors of the twelve newspapers in the area are cooperative, so we approached them all with the idea of an "Our Hospital" column which would cover the human interest side of what goes on in the hospital, in addition to the more formal news items. They all registered enthusiasm, and all twelve are now printing the column.

We just started it this year, but so far it's been most helpful.

Jerome F. Peck Jr.
Mount Kisco, N. Y.

Maybe They Might

Sirs:

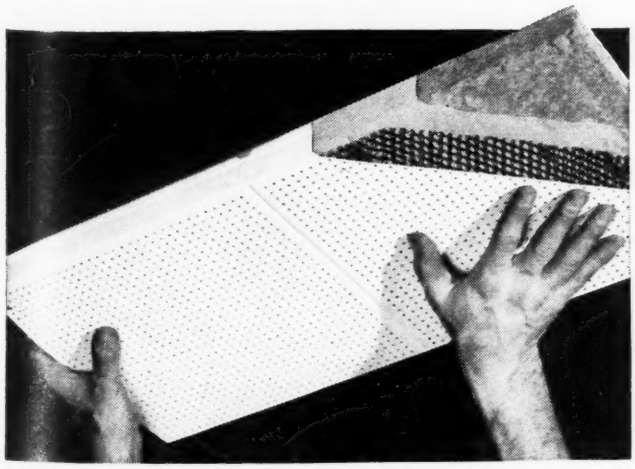
My trustees voted 10 to 1 not to get hospital literature. Many articles are fine but of course no good if not read. I put personal notes on some articles and asked later if they had been read. I never had the pleasure of an affirmative answer. What to do? Maybe the A.C.S. or A.M.A. might refuse approval when trustees do not cooperate.

New England Administrator

...KEEP IT QUIET!

OF all the disturbing elements in a hospital, noises from the kitchen are perhaps the most annoying to the patients. And they pretty generally make for unpleasant working and living conditions, too.

Smother kitchen noises effectively and permanently with Fireproof Gold Bond Acoustimetal! It provides a maximum of noise reduction as well as high light reflection. Particularly important with kitchens is the fact that the smooth baked enamel finish of Acoustimetal can be washed repeatedly, and when you redecorate, it can even be painted without loss of sound absorption. Acoustimetal is adaptable to remodeling as well as new building. The 12″ x 24″ perforated pans snap into patented T-bars mounted in the ceiling and are quickly removable for access to wiring, piping, and air ducts. True, Acoustimetal costs more than ordinary inflammable sound conditioning, but the savings in maintenance more than cover the difference. For complete details, write for our new Acoustimetal folder.



Gold Bond Acoustimetal—The Fireproof, washable acoustical tile for exacting sound control.

You'll build or remodel better with **Gold Bond**

NATIONAL GYPSUM COMPANY • BUFFALO 2, N. Y.

Over 150 Gold Bond Products including gypsum lath, plaster, lime, wallboards, gypsum sheathing, rock wool insulation, metal lath products and partition systems, wall paint and acoustical materials.

SMALL HOSPITAL QUESTIONS

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

Don't Neglect Night Shift

Question: What special considerations should be shown night employes? What food service could and should be provided for them? Is extra pay justified? Necessary?—N.I.McC., Ill.

ANSWER: Too often night employes feel that they are the forgotten people of the hospital family. Special consideration in regard to selection of vacation time and days off duty is a factor in establishing good working relations. They are entitled to the same type of food and service that are provided for the day personnel. Extra pay is customary and justifiable as night work is generally considered less desirable.

Recently, we initiated a procedure that we believe will help to keep the night shift in closer touch with the rest of the hospital organization. We use a notebook report of morning conferences or special meetings. This notebook contains special instructions, changes in routine, and a summary of instructional conferences. This report is read by all nurses, such as night nurses and those on relief duty, who are not present at the conferences.—PEARL R. FISHER, R.N.

Problem of Nursing Mothers

Question: Will you let me have your opinion, based on your knowledge of common practice in civilian hospitals, of the problem: When a mother who is nursing an infant (up to six months) is admitted to the hospital for a condition unrelated to the infant, what is the usual practice in regard to the infant? Assume the mother's condition would permit nursing to continue. This problem frequently confronts us, and most Filipino women are nursing so that the admission of the child offers something of a housing problem. An economic problem is not involved as the only charge is subsistence.—A.R.G.

ANSWER 1: Most hospitals in this country do not take boarders because of (1) lack of space; (2) legal liabilities in case the boarders contract any condition through exposure. The usual method would be mediated by the age of the infant. A very young infant might be brought in at feeding time, though it would be better to change to a formula.—ROGER W. DEBUSK, M.D.

ANSWER 2: A nursing mother who is admitted to a hospital is usually separated from her infant. Before hospitals became so crowded it was not unusual for the hospital to admit the infant to the hospital's nursery for care. However, even under this type of an arrangement the baby was not allowed to go to the mother to be nursed.

It is recommended that mothers who have nursing babies should be separated from the babies upon entering a hospital. If a local condition, either economic or medical, demands that the baby also must be taken care of, then other facilities should be provided to take care of the baby separately. Any arrangement other than this should be done only upon the recommendation of the physician treating the case and in conformance with local public health regulations. — ROBERT BROWN, M.D.

Checking Credit Ratings

Question: Should the credit ratings of patients who make reservations be checked in advance of admission?—R.T.S., N.M.

ANSWER: In a community hospital where readmissions are high, this should hardly be necessary. The admitting officer in the average community hospital shortly becomes a credit bureau. Perhaps on a selected basis in certain areas the policy of obtaining credit ratings prior to admission might make sense.—WILLIAM J. DONNELLY.

Reservations Guide Only

Question: Are there dangers involved in making reservations far in advance?—W.B.C., Ill.

ANSWER: Reservations for hospital accommodations should always be accepted with "reservations," inasmuch as we cannot, like the hotel, turn down requests for admission to the hospital that may be of an emergent nature. Reservations do serve as a guide if we are careful to point out at the time the reservation is accepted that it is placed on the books with the understanding that it will be given preference to the extent that this is possible.—WILLIAM J. DONNELLY.

Controlling Odors

Question: What methods can be used to air out a foul smelling room hurriedly?—C.R.R., Calif.

ANSWER: We do not pretend to know the best method that may be used, but regardless of the method the source has to be removed before the odor can be controlled.

There are many deodorants on the market under various names that help to control odors. Some preparations of chlorophyll have been found very effective.

If the room is unoccupied, the problem is greatly simplified because the usual cleaning methods may be employed, and air can be circulated throughout the room, followed by a generous use of the chlorophyll preparation. If the room is occupied, and the source of odor cannot be removed, prompt disposal of excreta and drainage should be stressed, with the continuous use of the suitable preparation of chlorophyll.—JEWELL W. THRASHER, R.N.

Depends Upon Charges

Question: Can a segregated, well decorated and equipped basal metabolism room pay for itself in the small hospital?—M.M., N.Y.

ANSWER: Undoubtedly, a segregated, well decorated and modernly equipped room will encourage tests of this nature. As to whether it will pay for itself depends upon the charges made for such service and the frequency with which such tests are requested by the medical staff.—WILLIAM J. DONNELLY.

Price Adjustment Unwise

Question: Should a price adjustment be made for a patient who is called to come in and, upon arrival, no bed is available at the specified price?—M.W., Conn.

ANSWER: I do not believe that any adjustment should be made. The patient should pay for the accommodation utilized. A policy of granting adjustments generally leads to reservation requests for the lowest priced rooms and is obviously unfair to the hospital and to any who are unwise enough to make reservations for the higher priced rooms.—WILLIAM J. DONNELLY.

Looking Forward

Watch That Language!

ALL over the place, medical societies are passing hypertensive resolutions about dat ol' debbil hospital. In New York, for example, the State Medical Society has officially requested its council to "use its efforts to prevent hospitals from practicing medicine and interfering with the private practice of medicine." The Southern Medical Association is "alarmed at the growing trend of hospitals to encroach upon, enter into, and take over the practice of medicine."

In another recent resolution, the Missouri State Medical Association has noted and condemned "an ever increasing tendency on the part of hospitals and medical schools throughout the United States to engage in the practice of medicine for profit."

This is going too far. Any group of doctors that wants to can say that the employment of salaried physicians by a voluntary hospital constitutes the practice of medicine by the hospital. The courts have consistently held otherwise, but the point is a technical one and nothing much is at stake except a definition of terms. By adding the words "for profit," however, the Missouri group has raised a moral question that doesn't exist and has done a serious injustice to every voluntary hospital in the country.

Everybody who knows anything at all about the subject knows that none of our voluntary hospitals is practicing medicine or doing anything else "for profit" —within any reasonable or accepted meaning of the term. Obviously, the resolution refers to the common hospital practice of charging more than cost in certain revenue producing departments, such as radiology, in order to make up deficits in other departments. In the opinion of many thoughtful hospital people today, this practice is illogical and ought to be discontinued, since it taxes one group of patients for the benefit of all.

To call the income from these charges profits for the hospital, however, is to misuse, grossly and deliberately, a word that everyone understands to mean financial gain or advantage. There is no such gain or advantage anywhere in the operation of a voluntary hospital. The implication to the contrary in the Missouri resolution is false and wicked.

If these doctors want to call what hospitals do and have always done practicing medicine, that's their business. When they add the unfounded charge that nonprofit hospitals are seeking profits, that's our business. We don't like it.

The Rosenwald Fund

WITHIN a few days the Julius Rosenwald Fund, for more than thirty years an active force for good in American health and education, will cease to exist. In accordance with the stipulation of the founder that the principal sum be fully expended within twenty-five years after his death, trustees of the fund have voted to bring their work to a close this month.

In the words of Edwin R. Embree, president, the efforts of the fund since its creation in 1917 have been "to enrich and equalize opportunity for all Americans." A great part of the fund's $22,000,000 was spent building rural schools for Negroes in the South and in aid for Negro colleges and universities. Millions were spent to help bring about better interracial understanding and in scholarships and fellowships for both white and Negro scholars, artists and writers.

The fund has also made outstanding contributions in the field of health, establishing and developing hospitals, clinics and other health services, especially for Negroes, in many parts of the country. In a sense, every student of hospital administration, every graduate of a course in hospital administration, and indeed every hospital administrator, is a beneficiary of this fund, which initiated the movement to provide special training for hospital administrators fifteen years ago by establishing the first such course at the University of Chicago.

In much the same way, the millions of American families whose hospital bills are paid by Blue Cross plans owe a share of their relief from financial hard-

ship and anxiety to the Rosenwald Fund. When hospitalization insurance was in its infancy, this fund made a grant to establish an interplan research and coordinating agency at the American Hospital Association. With the continued help of the fund for several years, this agency became the Blue Cross commission, which has speeded and guided the extension of hospitalization coverage to 30,000,000 Americans.

Launched with the aid of the Rosenwald Fund, Blue Cross and education for hospital administrators have grown independently and will continue to grow, unaffected by the fact that the fund will now cease to exist. The two movements thus exemplify what Julius Rosenwald wanted to accomplish with his philanthropy: He wished to set in motion men and ideas which, once started, would have the vigor to carry on by themselves. That is why Mr. Rosenwald demanded that the principal as well as the income of the fund be spent within a comparatively short term of years. He was opposed to the dead hand of philanthropy that binds so many institutions to methods and projects whose usefulness diminishes with the passing years.

To the founder and the trustees who have served the Rosenwald Fund over the years, hospital people, among many others, owe a lasting debt of gratitude. There is no better way to discharge it than to carry forward the great work that this fund helped to start.

Art and the Hospital

WHEN *In the Hospital*, a symphonic suite by Dr. Herman Parris of Philadelphia, was performed for the first time recently by the Doctors' Orchestral Society in New York, most of the critics addressed themselves to the humorous implications of instrumentalizing hospital life. The newspaper columns were full of critical witticisms based on such hospital clichés as "The patient is doing as well as could be expected" and "It's a boy!"

Whatever the success of this particular work or this performance, the possibilities of giving hospital scenes and feelings serious artistic expression are exciting to think about. What a magnificent ballet, for example, could be developed around a hospital sequence!

Probably the hospital is too many-sided for full portrayal by the painter, who could scarcely charge the whole complex organism into the single moment permitted him. With its free movement through time and space, the literary form should be more promising. Not since Walt Whitman's vivid lines about nursing wounded soldiers, however, has the essence of hospital care emerged in literature. (Thomas Mann's "Magic Mountain" must be excluded as dealing with a special aspect of hospital life; the tuberculosis sanatorium is as different from the general hospital in emotional tone as it is in physical and professional facilities.) Many lesser novels have been projected with the hospital as backdrop, to be sure, but none of these really carries the reader into a living, three-dimensional institution.

Actually, the motion picture is the art form that should offer the richest opportunity to catch all the surging rip-tides of hospital emotion and activity. However, the economics of picture-making is such that films are produced to sell instead of to inform the human mind and spirit with truth. Instead of art, we get Dr. Kildare.

Bravo!

IN A recent resolution proposing that no medical society should "exclude any qualified physician from its membership by reason of race, creed or color," the New York State Medical Society has taken a forthright step toward closing the gap between American ideals and American practice. "The exclusion of physicians from membership on the basis of race," the resolution declared, "constitutes an affront to our colleagues, a degradation of the honored traditions of our profession and a violation of our American democratic ideal."

In many communities, action making local medical society membership available to qualified physicians regardless of race or color would put the next step toward equality up to hospitals, whose staffs, for obvious reasons of protection for patients, are often closed to nonmember physicians. It is an encouraging sign that some hospitals, including several in the South, have already led the way by adopting a policy of nondiscrimination. Admission of qualified Negro physicians to full membership on hospital staffs was a major recommendation of the Commission on Hospital Care and, more recently, was recommended by the hospital facilities section of the National Health Assembly. Plainly, hospital leadership is facing this issue squarely; individual hospitals and associations must not lag behind.

Inequality of medical facilities and opportunities between races has been a huge flaw in our free, voluntary medical system—probably the flaw that has provided the greatest amount of aid and comfort to enemies of the system, and the greatest amount of embarrassment to its defenders. In the long run, survival of the system will depend upon our ability to eliminate its flaws, and not on the tactical or political effectiveness of attack or defense. Right thinking medical and hospital people everywhere will applaud the action of the New York State Medical Society and urge their own groups toward similar action now.

A European Architect Looks at

American Hospitals

GUSTAF BIRCH-LINDGREN

Architect
Stockholm, Sweden

A HOSPITAL has to answer to all aspects of human life, from the birth to the grave. At the same time, the hospital ought to be a good piece of architecture, reflecting harmony, good taste, and pleasantness—cheering up the person who approaches it as well as the patient who stays inside.

All these things must be weighed against one another and brought to balance if the hospital as a whole is to be effective. No wonder the ideas of how to plan hospitals differ in so many ways! No wonder hospitals are so unlike each other! A good hospital always is a compromise among different forces brought to rest and harmony.

CANNOT MASTER EVERY PHASE

These forces are never the same; local conditions, patients and medical demands vary, not only in place but from time to time in the same place. There are always new methods of treatment, new specialties, new working conditions, new demands of every kind, social and medical, so that it is far beyond the abilities of any one person, whether a doctor, an administrator or an architect, to master every phase of hospital activity as it affects planning. But it is essential that at least one person involved in hospital planning should be able to look away from the factions and functions involved, see behind the problems of the day, and get a presentiment of future development.

I think the hospital architect must try to reach this point of deeper knowledge, because he has perhaps the best opportunities not only to learn about all sides of hospital activities but also to know through his technical education and experience what can be carried through in practical life. Nevertheless, few practicing architects seem to observe the possibility of entering the hospital field this way—that is, combining hospital practice with theoretical studies.

When one is trying to look over the whole field and see what will come in the future, there is nothing like travel. In spite of different habits, social conditions and economic structure, medicine, hospital care, and hospitals are largely international. Thus travel gives one a chance to pick up new ideas—to compare, to adopt, or to reject.

Three times during the last two years I have had an opportunity to visit the United States for hospital studies, and every visit had its influence on my own work in Sweden. These are some of my impressions and reflections.

I miss in America the feeling that a hospital is a living organism. The ever increasing volume of laboratory work and the increasing demand for x-ray pictures are examples of growth. If a hospital cannot answer this demand, it cannot give the best quality of care to its patients. I have seen hospitals in which ward units were changed into laboratories!

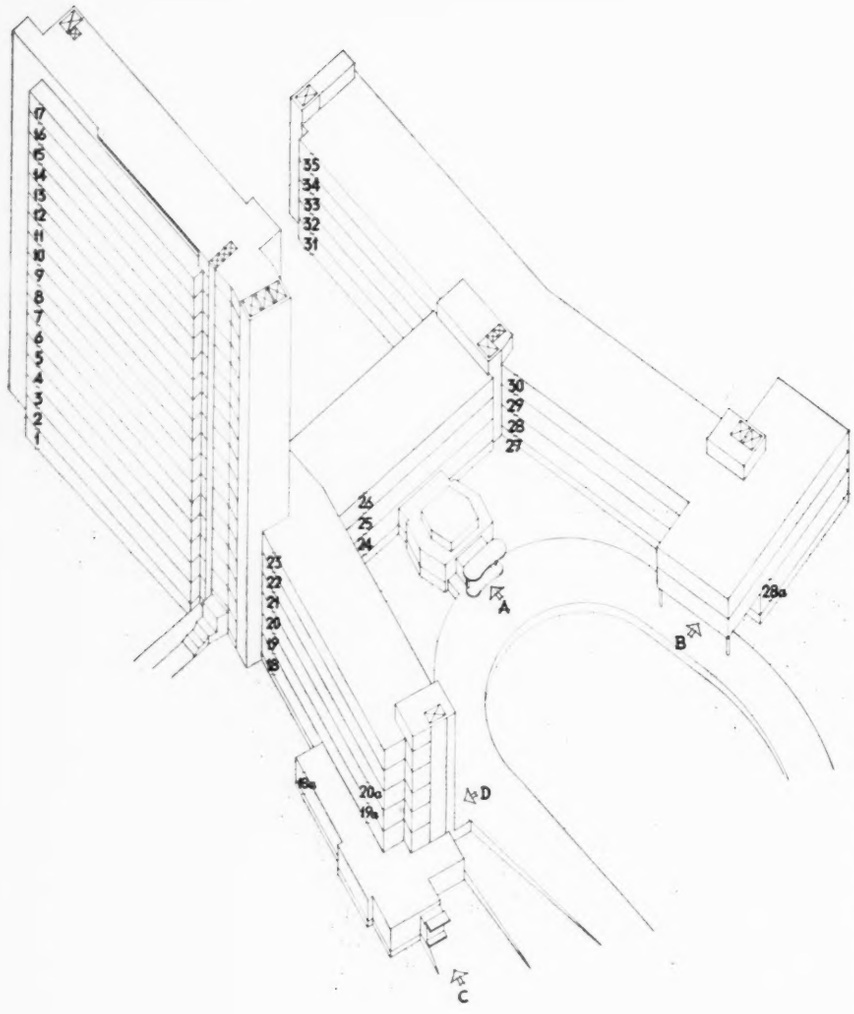
Perhaps this seems extreme in a time characterized by an increasing demand for beds. But is it, really? Certain illnesses need comprehensive laboratory work. If the laboratories are inadequate, its work will inevitably be delayed, and the patient will be kept in the hospital longer than is necessary, thus taking the bed from the next patient. The number of beds in a hospital is no measure of its capacity; it is the number of treated patients that counts.

The demand for beds is constant and always will be. Population increases; medicine masters new illnesses; the average length of life increases, and an older person spends more time in the hospital than a younger one. Thus the demand for beds and other hospital facilities will always, automatically increase. If the development of a hospital is stopped, for one reason or other, it will soon be behind the times.

THE NEEDS INCREASE

How often do you hear: "Well, these are our needs; when we have them we will be absolutely safe for the future." I have been called three different times in a twenty-year period to plan enlargements for one county hospital. The first time, we built a new power plant with 100 per cent reserve capacity. Now this power plant is enlarged; the number of beds has increased from 173 to 573, with corresponding additions to all facilities. Another Swedish example is a hospital that was built in 1928 with 101 beds and now has 366 beds.

Plainly, if hospital plans lack flexibility and thus hamper sound economical enlargement, they are wrong. At the same time, the hospital grounds must be ample. It seems to me that too little attention is paid to this fact in America, perhaps because there is a general tend-



KEY TO DRAWING

1. Central storerooms
2. Central laboratory
3. Maternity septic ward
4. Maternity aseptic ward
5. Gynecological ward unit
6. Surgical ward unit
7. Surgical ward unit
8. Surgical ward unit
9. Surgical ward unit
10. E.N.T. ward unit
11. Eye ward unit
12. Medical ward unit
13. Medical ward unit
14. Medical ward unit
15. Medical ward unit
16. Medical private ward unit
17. Surgical private ward unit
18. Central laboratory

18a. Children's health department

19. Maternal health department

19a. Receiving department

20. Septic operation

20a. Delivery department

21. Infants
22. Children's medical ward unit
23. Children's surgical and psychiatric ward units
24. Lobby
25. Administration
26. Central record department
27. Physical therapy
28. Surgical outpatient department

28a. Emergency department

29. X-ray department
30. Operation department
31. Locker rooms
32. Dispensary
33. Medical outpatient department
34. E.N.T. outpatient department
35. Eye outpatient department

A. Main entrance
B. Emergency entrance
C. Children's entrance
D. Maternity entrance

ency to place the hospital near the city's center where the ground is expensive. This may lead to disaster in the future. In many cases it is far better to place the hospital out in the surrounding countryside where ample space can be provided and where the air is fresher and the grass greener. In our atomic bomb age, there are other reasons, too.

To compensate for lack of ground space, the skyscraper hospital was born. It is a magnificent structure from the outside. But how about provision for enlargement of the x-ray and laboratory departments on the upper floors, and how are working conditions in the kitchen deep down in the center of the building where fresh air and daylight have no chance to find their way?

A foreigner who asks, "Is this really necessary?" is assured that central tray service is worth whatever it costs. But, during my last visit, a prominent American doctor told me that he had weighed returned food and found it to be 56 per cent of that served. Then he introduced bulk service and reduced the return to just a small amount. Now, the food carts are driven around the wards, and each patient gets hot food at the bedside, choosing just what he wants from a moving cafeteria, electrically heated, just as it is done everywhere in Sweden.

It is necessary to keep in mind that hospital meals in America customarily consist of more items, which makes bulk service a little more complicated. But I got the impression that the bulk system decidedly is on its way. With the bulk system, it is possible to remove the kitchen and the dining rooms from the basement to a separate building, allowing much more freedom to plan and develop both the hospital itself and the kitchen, and giving the workers better working conditions.

If I criticize the serving of patients in America, I must at the same time acknowledge that the serving of the staff by the American cafeteria system is being used more and more in Sweden. It is so practical, economical and convenient that it is now adopted in all new hospitals, exactly according to the American style.

Going back to the skyscraper hospital, it is necessary for me to admit, a little reluctantly, that there are certain advantages connected with it from the Swedish point of view. This is because of a change in conditions rather than opinion. The reason is that, at present, nurses and all other kinds of help are hard to get, so that facilitating traffic within the hospital by mechanical means is very important, even if it is costly. The skyscraper hospital aids the solution to this problem, as the traffic is moved vertically by means of elevators, dumbwaiters and pneumatic tubes.

It seems to me that the best solution may be to combine the Swedish type and the American skyscraper hospital in such a way that the ward units are placed one upon another, whereas the treatment and outpatient departments are planned as lower wings to the high building. In a word, the bed building can take the form of a skyscraper, but the treatment buildings or wings ought

to be planned in such a fashion that they can easily be added to, or new stories can be put on top of them.

How this can be carried out in practice is exemplified in Uddevalla County Hospital, the first fifteen-story hospital building in Sweden. Another project planned on the same principle, with a twenty-story "bed building," is in work and seems to be developing very satisfactorily.

The Uddevalla project reflects another common problem: Is it better to enlarge an old hospital by adding a new wing or to build a new hospital? In one such case in Sweden, a competition among four hospital architects was held, and the result was that in this instance it was both cheaper and more practical to build a new hospital for the central activities, surgery, medicine, gynecology, obstetrics, ophthalmology, otolaryngology and pediatrics, and with the smallest possible change devote the old buildings to other purposes, such as convalescent care and psychiatry. The new and old hospitals are combined by a tunnel. Altogether there will be about 440 beds in the new building and 180 beds in the old buildings, and another separate building for communicable diseases will be added.

The Uddevalla Hospital is a county hospital in a rural district. Swedish city and university hospitals have shown a tendency to grow far above that size. One hospital is nearing 1700 beds, and at least five other hospitals have been growing until they are now found in the group of about 1200 to 1500 beds.

Of course, the bigger a hospital is, the bigger are the opportunities for bringing together all the different kinds of specialists and services into a unit serving the sick in the best way, and, of course, teaching and research are aided, too. On the other hand, the big hospitals have their great drawbacks. They are lacking in close personal contact, are too much spread out, with too much nursing personnel required, and heavy costs are a result. Personally, I think it is impossible for an architect to plan a 1200-bed hospital in such a way that the design will show a suitable, compact working unit, with short connections between different departments and ample possibilities for future growth.

It seems to me that 700 to 800 beds should be the maximum to start with, especially if future growth is considered, but an even smaller number is an advantage. This rule seems to be observed more in America than in Sweden. On the other hand, the lower limit seems to be little considered in America. Yet it is a fact that satisfactory, complete medical service cannot be given a patient in a small hospital. For complete care, the combined experience of at least a surgeon, an internist and a radiologist often is necessary, and these men often need full equipment, which cannot be at hand economically in a small hospital.

How these facts influence Swedish hospitals can easily be seen. Every ordinary surgical hospital, generally of 70 to 100 beds, is already on the way to being combined with a medical unit, with an internist as chief, and a complete x-ray department with a full-time specialist. Added to these resources is a complete central laboratory. A hospital with these treatment facilities cannot, in Sweden, have less than 150 beds, if it is to be a good, economical working unit and keep the specialists busy.

Minor hospitals can never be given such facilities that they can serve the sick at a high enough standard; such hospitals are therefore not favored any more in Sweden. Of course, in some places where the population is sparse, even cottage hospitals (up to 30 beds) are still necessary, but with increasing motor traffic and better roads, these will decrease gradually.

Conditions in America are not entirely comparable, as the Swedish hospitals always use full-time doctors. Nevertheless, it might be interesting to point to the general trend in Sweden in favor of turning the 70 to 100 bed hospital into a 150 to 180 bed hospital as a means of improving the medical care of the sick. Hospitals smaller than 150 beds are seldom built today.

Of course, cooperation with bigger hospitals is the way to get the most out of the small hospital. This must continue all the way up to the biggest medical centers, in a coordinated hospital system, as envisioned for the United States by the Commission on Hospital Care. That it will be tremendously difficult to carry such a plan through is obvious in a country where most hospitals are private. In Sweden, where all hospitals are owned by county, city or state, it is no problem at all. It is perhaps presumptuous of an architect to judge medical results, but I can't avoid the impression that American doctors many times

Architect's rendering of the Uddevalla Hospital which follows the plan (shown on the opposite page) of placing ward units one upon another, while the treatment units are located in the lower wings.

do excellent work *in spite of bad working conditions and inadequate resources in their hospitals.*

Central planning, coordination of facilities, and development of a hospital system based on the needs of the population mean hospital building on a great scale. During a time when prices go up, the value of money and interest go down, and taxes are high. If, earlier, the income from one private patient would provide free care to perhaps two patients, the proportion now is reversed, so that two private patients perhaps can help just each other—if indeed at today's prices the private patient can pay anything over his own cost. Many clever brains are working to find a way out of the hospital's financial situation without state support, bringing with it the heavy hand of governmental authority and bureaucracy.

Of course, state support is not desirable, but it is hard to see how it can be avoided. I think it is inevitable, at least to a certain degree. The experiences in Sweden are not discouraging. The argument is sometimes heard that the medical profession in Swedish hospitals is socialized. This is not at all the case. All full-time doctors in our Swedish hospitals have the right to private practice within the hospital. Socialized medicine ought not necessarily to be the result of governmental support.

Another thing is the fear of political influence and bureaucratic red tape. To a certain degree, these might follow governmental aid to hospitals. But if it comes to the point where disadvantages of this kind have to be weighed against the evils of an inadequate hospital system, I think there is no doubt which will be preferred.

The conclusion would seem to be that those who fight against governmental support and coordination of hospitals fight a hopeless fight. It would be far better to recognize the development in time and to find some middle way out.

V.A. HOSPITAL PROGRAM

Discussing the coordination of hospitals in America, I think attention must be given to the development of the veterans' hospitals. From an outside point of view, it is a little strange that such a large group of the entire population is now eligible for lifelong free hospital care through the Veterans Administration, even if the illness has nothing to do with its military service. At any rate, the V.A. development is such a big factor to contend with that it must be taken into consideration wherever regional planning for cooperation among hospitals is discussed.

If American hospitals lack cooperation among themselves, they don't lack cooperation among different departments within the hospital. The centralized operating rooms for surgery, E.N.T., gynecology and other departments, as well as the centralized sterilizing department, are features which I have picked up and am now trying to introduce in Swedish hospitals. The same is true of your central record system. Also, many of the mechanical developments, such as pneumatic tubes, elevators and lighting fixtures, are more advanced in America than in Sweden. Too, the soundproofing, or rather sound-deadening through acoustical materials, that is frequently used in American hospitals seems to be a fine thing.

Personally, I have learned more about hospitals in America than in any other country. When traveling around and studying developments in various countries, it is much easier to get a feeling for what is coming. Otherwise, it is so easy to be caught by habitual and tradition bound thinking, to lose the ability to distinguish between what is essential and what is relatively unimportant. In all cases, however, I think it helps a great deal if the hospital is regarded as a living organism, always developing and always growing. This concept adds interest to the planning of hospitals, in which all phases of human life are reflected and which fill such a big place in the social and charitable world.

ADMINISTRATIVE CAPSULES

The Volunteer Hostess

E. M. BLUESTONE, M.D.
Director, Montefiore Hospital, New York City

FOR those who are still in doubt as to the value of the volunteer, as compared to the pay roll worker, in the peacetime hospital of the postwar era, and for those who prefer to conduct their hospitals with a paid staff only, the position of the volunteer hostess in the admitting room might be considered in comparison with that of the paid admitting officer.

The admitting officer is a technician who follows a routine, often a hurried routine, over a long period of time, and is likely, therefore, to become impersonal in dealing with the sick and their families. From the point of view of the hospital employer, this officer tends to be protective and does, indeed, have an important place in the field of hospital economics. Moreover, the admitting officer is paid to be kind to patients and often finds that this duty is difficult to carry out while appraising the ability of the patient to pay.

By contrast, the volunteer hostess meets the patient unhurriedly, out of sheer humanity, without any thought of a financial return, and untroubled by the financial contribution of the patient. Since it takes several hostesses of this kind for every pay roll worker, she brings with her, from the world outside of the admitting room, a personality that competes easily with that of the admitting officer. You cannot buy a good admitting room hostess with a salary. Here is at least one situation in the hospital where the volunteer has a permanent place, regardless of the finances of hospital or patient.

The volunteer will still be with us, long after such world-shaking events as the struggle between capital and labor will have been solved.

Hospitals Cannot Turn Away From the Problem of

THE PROBLEM DRINKER

SIGMUND L. FRIEDMAN, M.D.

Director
Mount Sinai Hospital
Cleveland

THE severest indictment of hospital facilities for the treatment of alcoholism was written by the hospitals themselves into Corwin's and Cunningham's Report of 1944:

"The . . . General Hospital, as well as the other local institutions, have all adopted the same policy due to overcrowded conditions, 'that alcoholism is a self-induced condition, therefore why take up space that might be given to an acutely ill person who might be cured.'" And:

"If, however, the hospital is used repeatedly merely as a place to sober up instead of being put in jail or being cared for by their friends or relatives, with no intention of quitting the practice, it seems futile and a gross misuse of medical or hospital facilities, when hospitals, physicians, and nurses are so sorely needed by those who are ill or injured." And once again:

"To our house staff they (the alcoholics) are a disgusting, disagreeable annoyance."

I submit that these are excuses offered, unconsciously it may be, to cover up more fundamental reasons. One reason is probably a fear of grappling with a problem, so much of which has, until now, been outside the traditional orbit of hospitals, for the problem drinker has been, in the traditional sense, more than a medical problem: he is a public health and a social problem as well.

OUT OF SIGHT, OUT OF MIND

The hospitals, by not admitting the alcoholic, have turned their heads away, not only from the individual patient but from all similarly stricken. They have, it would seem, hoped that once out of sight, the alcoholic would also be out of mind. But at long last they are learning that this is not to be. The extra-hospital community is beginning to wonder why the hospitals, particularly the voluntary general hospitals which it supports, have refused a responsibility so obviously theirs.

It is true that not all voluntary general hospitals refuse admission to the alcoholic, but so many do that here again the exception proves the rule. It is true that the voluntary hospitals can legally determine the types of patients they will serve, but their moral responsibility to the community prevents their standing on legalistic ground. It is true that there are difficulties in the bed care of these patients, but they are certainly not insurmountable difficulties.

Finally, it is true that there are other medical facilities for the care of the alcoholic: the public general hospitals which cannot ordinarily be as selective as the voluntary general hospitals; the hospitals for the mentally ill—but not all, not even a majority, of the alcoholic patients are mentally ill; the private institutions established for the "treatment of alcoholism," to which only the comparatively wealthy can go, and then, almost always, for only perfunctory care. Of these, few, dangerously few, attempt long-term hospitalized treatment; fewer still attempt follow-up care with its attendant social service and rehabilitation programs.

Alcoholism is an illness, which, whatever its causative factors, may end in "organic" disease. These "organic" diseases have been studied in the general and psychiatric hospitals for many years — studied as other diseases have been, by concentrating on the diseased organ, not on the patient. And this is the hub of the problem.

For the "era of laboratory medicine," which set in some half century ago, appears to be nearing its end. During this era the patient was divided, redivided and subdivided, and he became nothing but a bag in which his organs frequently seemed to have no relation to each other and rarely, if ever, any relation to the outer world. Disease came to mean disease of an organ, not disease of a patient. Disease meant an isolated phenomenon due to a simple specific cause, unrelated to a person with a unique past and memories of that past, with an all too frequently troublesome present, and with a future and aspirations for that future.

DEVICE OF THE INTELLECT

This isolation of disease from patient was a device of the intellect. Etiology, prognosis and therapy became abstractions. This isolation was possible only as long as physicians could speak confidently of single, purely physical etiological agents. It was possible only until they realized that man's social as well as his physical environment can of itself alleviate or, on occasion, even prevent, or produce and aggravate disease on the one hand and, on the other, be an important factor in the promotion and maintenance of health. And, with this, came the realization that many diseases are generated and nurtured in an atmosphere of poverty, not only because of the physical conditions but also because of the hatreds, fears and insecurities associated with indigence and destitution.

Inasmuch as cause and treatment are directly related, "cure" consists not solely in the clearing of the pneumonic or tuberculous pulmonary process but in restoration of the patient to the greatest possible functional efficiency in society.

This means that medicine is confronted with several new problems:

1. A reexamination and reevaluation of disease.

2. An examination of those conditions in society which detract from, or promote, mental or physical health.

3. A reevaluation of therapy and therapeutic agents.

A beginning of a solution of these problems has been made in some of the universities and hospitals, which have, each in accordance with the degree of awareness of its own physicians and trustees, expressed their desire to grapple with the problems. The approaches are different; the methods vary. But the realization is there that another break with the immediate past is necessary, that, indeed, it has already begun.

For those few hospitals which have accepted the challenge there are a new coherence in thought, a new outlook on life, which have given direction to action so that they are now able to plan their future in terms other than those of buildings.

STUDY ETIOLOGIC FACTORS

The implications of the acceptance of this concept are many. Hospitals can no longer concern themselves merely with those patients who come seeking care for illness or injury. They must do more than practice the traditional preventive medicine of an outpatient department of a follow-up service. They must interest themselves in the study of all etiological factors—whether they be bacterial, physical, emotional, hereditary or social; they must bring into their orbits students from any field, provided only that those students have a contribution to make.

The contribution may be a point of view or a technic, ways of looking at facts, or methods of accumulating and analyzing them. If these students happen to be social scientists, so much the better. But social scientists cannot accumulate facts by staying within the walls of the hospital. They must, at least some of the time, go out into the community. And it is this type of search in the community which is new to hospitals.

But the objective, no matter by what route it is reached, is always the same: optimum health for the individual member of society.

Two routes have already been suggested—the traditional type of research (including the psychiatric) and social science. But the public health workers have also been cutting their way through. They have developed technics, contributed a body of literature and "produced results." Close coordination between the world in which they work and that of the hospitals must be sought —not on a superficial level but on both planning and working levels.

It is essential that these routes, together with others which can be readily plotted, be used for all diseases, but in none is it more essential than in alcoholism, which has, so apparently, several etiological factors, not a single etiology. These factors must be sorted out and studied, and treatment must be aimed at their removal or correction. Apology for this obvious statement would not be necessary were it not for the simple fact that only a few long-range etiological studies in alcoholism have been conducted, and the rational treatment based on them has only rarely been applied.

Both study, either in the laboratory or in the community, and treatment should be centered in a hospital to which the alcoholic patient can be admitted without the stigma so frequently associated with admission to specialized institutions. Treatment, to be effective, necessarily includes the inculcation of an attitude in the patient. The feelings of shame and guilt, which so many problem drinkers have, must, so far as possible, be lightened soon after admission.

The alcoholic must be made to feel that he is sick, and that he is being treated as a sick person, not as an object of scorn or contempt or as a recipient of some dried crumbs of medicine grudgingly thrown at him. He must be made to realize that his hospitalization is only the first step in a long series of steps which, it is expected, will end with his return, fully functioning, to society. He must be made to feel that his return to society will be more than passively accepted, that his return is being actively encouraged and desired by society because of its need for his contribution to its welfare.

No patient can be given such hope and incentive only by talk, no matter by whom given or how skillfully; the entire hospital personnel must be so educated and coordinated, the treatment must be so planned that the patient sees the end in view: rehabilitation. This is, of course, something more than mere physical restitution to functional efficiency; it includes vocational, psychiatric and social restoration.

The hospital service for the alcoholic must be complete. It must consist of a working team of physicians of different backgrounds: internist, psychiatrist, neurologist, chemist and pathologist. It must have nurses trained in psychiatry as well as in the care of general medical patients. It must have medical social workers, also with training and experience in psychiatry, and rehabilitation workers with training and great understanding.

COORDINATE SPECIALISTS' WORK

The rôle each of these specialists will play will, of course, be carefully thought through and coordinated. New working relationships may be found necessary in view of the fact that, in the treatment of the problem drinker, successful therapy is as frequently dependent on the family's readjustment to the patient and his problem as it is dependent on the patient's readjustment to his milieu.

The Alcohol Service of which we speak must have free access to all the facilities which are today required for diagnosis and are most frequently found in general hospitals.

The patient, once discharged, will, necessarily on such a service, be referred to the outpatient department, and this will be staffed by the same professional people who serve the hospitalized patient and his family. The need for the indivisibility of hospital and outpatient department cannot be overstressed.

Incidentally, all of these responsibilities can be discharged properly only if the hospital is readily available in a purely physical sense—another and not unimportant argument for the use of the voluntary general hospital as opposed to the usual specialized institution, whether psychiatric or for alcoholics.

These responsibilities can also be discharged properly only if the Alcohol Service is part of an integrated program which calls on the resources of government consultation bureaus family relations bureaus, public health and public welfare departments, a visiting nurse service, and,

no less important to the project, the medical and personnel departments of industry.

The job we have so glibly planned for this Alcohol Service is difficult. For it will be confronted daily with the need to choose between what is stable and worth preserving and what is deadening precedent, between what may be regression and what, at a much later date, may prove to have been progress. Yesterday's tradition will (we hope) not be permitted to blur today's vision or paralyze tomorrow's performance. A large order, but no larger than the problem for which the Alcohol Service will have been created.

To return to the main thesis: Alcoholism is an illness, which, because of a social attitude and a medical tradition with respect to it, has been inadequately treated, the social attitude being partly that of praise for the man who "can hold his liquor" and partly scorn for the man who becomes a problem drinker; the medical tradition being the erection of artificial barriers between what is medical and what is social. Logic demands that attempts be made to modify cultural attitudes and to level the barriers between so-called "medical" and so-called "social" problems.

In St. Barnabas' Book—

EMERGENCIES COME FIRST

MARTHA C. LOCKMAN
Superintendent
St. Barnabas Hospital
Minneapolis

DURING the war years and continuing through to the present, the strain on room clerks to make bookings, keep the occupancy up, provide for emergencies, and satisfy the medical staff has been a real challenge. Minneapolis hospitals had a noticeable slump for several months, but now the problem has become a reality again, and inasmuch as the old, well worn phrase, "You know there is a war on," is no longer applicable, the details of better booking arrangements must be solved to demonstrate efficiency and satisfaction to the patients, the doctors, the administration, and the cooperating departments.

NO FORMULA ESTABLISHED

I am sure that in many hospitals no formula has been established for determining how many patients should be and can be admitted, and when the room clerks found extra beds available and that they had not arranged for the correct number, they simply filled in with emergencies. However, such an arrangement has been of some cost to the hospital inasmuch as beds may have been vacant for a day, resulting in less income, and in the meantime, doctors have become impatient because they could not arrange bookings at once. All of this has resulted in the usual "gripe sessions" in the staff room—always exaggerated—and everyone has felt the strain.

Most serious of all, a patient who may have really needed care might have been refused, and the hospital criticized for not filling the community need. We say public relations is a major consideration, and now we must prove that our concern with the patient is paramount and make sure that our admission department is taxing all efforts to accomplish the task of taking care of the community needs.

We have said, at St. Barnabas, that we *will* take care of all emergencies of our medical staff. The doctors are willing to book routine cases in advance, perhaps as much as six weeks, but emergencies cannot wait. This policy has created problems, but if these problems are realized and everyone works toward solving them we believe it can be carried out, and we believe it is necessary primarily for the patient.

One cannot have just anyone handling admissions. The person in charge must demonstrate that she has first the proper personality to deal with doctors, inspire their confidence and respect, and do the job. It takes time, counseling and understanding on the part of the administration in direct contact with this problem to develop in this individual such assurance and efficiency that the administrator knows that the job will be done even when he is not on hand.

We cannot have a person who merely says "Yes, doctor, we will admit your patient" and then does nothing. The words "follow through" probably never mean so much as right in this initial contact with the patient. The room clerk must be discerning. By trial and error, she will develop a flair for knowing when an emergency is an emergency, and regardless of her private suspicions she must rely on the doctor's statement. Repeated misinformation from a doctor is a problem for the administration.

TACT IS REQUIRED

The room clerk, as an individual, must be intelligent and possess tact. Occasionally, it may appear to other employes that the room clerk has a soft job—mostly conversation with the doctors. Such conversation is necessary, and it is only by not being abrupt that she can gain the cooperation she needs. The doctor must have the assurance that when he has an emergency the room clerk means it when she says she will get into the problem at once. On her part, it may require contact checking of facilities, obtaining information by devious means as to possible discharges, and repeated contacts with employes of

other departments, all of which must be done intelligently, efficiently, tactfully and with no delay. She may need assistance, and someone should be available to help. When the administrator or assistant has helped the admitting officer with a problem, she will remember the solution and be able to handle the next case with similar problems by herself.

To those who have not actually handled admissions, it may sound easy, but it isn't always, and to avoid resulting tensions requires constant effort on someone's part to instill in the entire staff the understanding that emergencies must be taken care of, and that we cannot let a patient die because we have no bed.

Recently, we planned, when the census was low, to take away a two-bed patients' room and make it into another examining room. We were fortunate not to have rushed too hurriedly because we have had to retract, and it is a patient's room still. The same was true when we had plans under way for extra office space. We need both but we feel the need to care for patients more.

We have well in mind not only our actual facilities for bed complement but where an extra bed can be set up if needed. We have prepared the nursing staff to know that these extra beds may be used—not routinely but for emergencies. We have made the housekeeping department aware that on occasion we cannot allow it the usual time to wash or paint a room. When we can we will, but when an emergency means action, we expect it.

STAND BY TO HELP

When admissions are pouring in, and the situation is acute, we don't just leave it — we stand by to help bridge the gaps and ease the tension. More than that, we try to keep in mind that when everyone exerts extra effort at a time when quick thinking and action are vital we compliment the employes for a job well done.

At night, when we reach the peak on admissions, we make rounds and get the complete picture so that we can suggest something, perhaps shifting of cases, getting beds allocated properly, perhaps arranging discharges that could have been made but were just delayed because the doctor didn't realize it made any difference.

We have investigated the convalescent home situation. We have printed lists for the doctors who may not know of any place to suggest for a patient requiring such care. We call and check about vacancies for the doctor. We explain the various arrangements to patients' relatives, and in this regard we have had a noticeable amount of cooperation and have had beds available which otherwise might have been occupied days or weeks longer than necessary. We prepare a list of long-stay cases and keep a running record of the doctor's remarks about the case and why it is necessary (if it is) for a patient to remain. We present a report to the executive committee of the staff as to which patients remain over thirty days, over sixty days, and so forth, and not infrequently the knowledge that this report goes to the staff brings results.

Having had a brief lull in admissions during which such cases were not pressed for discharge, we are now faced with the problem that the nurses feel they are overworked, and a certain tension is apparent in spite of the fact that we know our staffing is not depleted. The patient must not sense this. She must not be taken to the floor for admission and have a nurse glare at her as if to say "Not another patient!" It may be difficult to accomplish, but someone must make the nurse realize that, regardless of her personal feeling, the patient must be received graciously. We believe we are accomplishing this, but it takes constant effort on someone's part.

To be specific, one day last winter we had no beds for adults available. We had calls from two doctors regarding emergencies, one patient had acute appendicitis, one had an obstruction from swallowing a chicken bone. We agreed to take both and knew that meant quick action.

The room clerk checked all floors personally to see if she had not heard of all discharges. She found one. Owing to the pressure of work, the nursing staff, on one floor, had not reported a prospective discharge. The patient was waiting for her husband and was in the process of dressing. The situation was explained to the supervisor and to the patient. She vacated the room within about ten minutes. On the same floor we set up a bed on a sun porch. The sun porch was not chilly, but in Minnesota winter temperatures reach well below zero, and we preferred to have the appendicitis patient in the room rather than on the sun porch.

ALL HANDS ON DECK

We hoped the patient who had swallowed the chicken bone would arrive first as she could be handled in the emergency room and later brought to the floor. This did not happen, and the patient with appendicitis arrived first. She was so acutely ill it was necessary for all hands on the station to get the discharged patient dressed, placed in a waiting room, get the bed made up quickly, and admit the emergency without delay, arrange for the resident to see her, and arrange for laboratory work. All this was accomplished and, in spite of the effort required, when it was all over those who performed these tasks were proud of their job and rightly so. The other case arrived at that moment, and everyone went into action again. About that time, still another case required admission. A group of doctors was chatting in the staff room. When the problem was presented to them, they all got busy and made rounds and discharged three of their cases. And so it goes, but we are all working together now, and we hope it continues. One thing about the problem is that there is never a dull moment, but if we know we are doing the best we can for true emergencies, the feeling of satisfaction quickly spreads throughout the whole institution and does much to promote efficiency and accomplish what we set out to do—take care of emergencies.

"We do what we are asked" in this case means that the men on duty are sharpening needles.

AMBULANCE SERVICE

"Courtesy of the Community"

ROBERT G. BOYD

Director
Morristown Memorial Hospital
Morristown, N.J.

A SOMEWHAT unusual but extremely effective form of community teamwork ensures continuously efficient ambulance service for Morristown Memorial Hospital, Morristown, N.J. The success of the arrangement results from a closely knit and friendly cooperation between volunteers and professionals. Another key factor is that the specialized training of both groups has instilled in the individuals the kind of thinking and habits that are absolute requisites for the proper handling of emergencies.

Briefly stated, the service is divided about equally between the volunteers and the professionals. Each group is in charge of a twelve-hour period every day of every week throughout the year. The volunteers are on duty from dark to dawn, and the professionals (a group of firemen) for the other half of the twenty-four-hour day. Exact duty hours are 7 p.m. to 7 a.m. and 7 a.m. to 7 p.m., respectively.

A rigid inspection service is performed by both groups, but the primary responsibility for the maintenance of Morristown Memorial's two ambulances is placed on two of the firemen. These two are paid a monthly fee for their maintenance duties, which include:

1. Seeing that the vehicles are properly fueled and have water in the radiators and batteries.
2. Charging the batteries.
3. Adding oil to the crank-cases.
4. Washing, polishing and cleaning the vehicles.
5. Getting authority to have general lubrication or repairs in a local service station or garage.

As occurred in many hospitals throughout the nation, a USAAC unit was organized at Morristown Memorial Hospital a short time after the start of World War II. Other members of the hospital staff who were on duty here during the war often hark back to those war years and wonder what the institution would have done without the loyal support of these corpsmen. Two members of the unit were on duty for the twelve-hour vigil from dark to dawn, *without a single failure,* throughout the war years. They would often come to the hospital direct from their regular work and be "on the go" every minute until midnight or even later.

An unwritten rule in which the corpsmen have always taken justifiable pride is that they never permit late hours or tiring duties at the hospital to interfere in any way with their performance record in their regular jobs. Of course, they usually do have a chance to get a fairly sufficient night's sleep as they have a specially assigned room in the interns' quarters. They seldom are in bed before midnight, however, and may have their sleep interrupted at any time by a call for an ambulance or some other emergency around the hospital.

Illustrative of the varied duties that the corpsmen may be asked to perform is an incident that occurred here after midnight some months ago. The two corpsmen on duty had just returned from an ambulance call and were about to retire, hoping for at least three or four hours of sleep, when there was a telephone call for help in one of the patient's rooms.

One of the corpsmen—who happened to be the huskier of the two—had not yet taken off his khaki uniform, so he hurried to the room in question. He found one of our nurses trying in vain

Local firemen make good use of their off-duty hours by serving as ambulance drivers for Morristown Memorial. They also assume responsibility for the maintenance of the vehicles.

to use moral suasion with a patient who had just been injured and brought into the hospital in a most uncooperative state. The patient was lying on the floor and refusing to get into bed; he wouldn't budge one inch for the nurse. When the big corpsman walked in, however, the situation quickly changed. The patient took just one look at the khaki uniform and determined approach and quickly got into bed mumbling, "I can't fight the army!"

It should be emphasized that the corpsmen never have in any way attempted to restrict the duties that they may be called upon to perform. When someone tries to find out what their duties are the usual reply is: "We do what we are asked." And they have always taken special pride in doing just that! Primary duties include driving the ambulances, filling oxygen tents with ice, putting up Balkan frames, and collecting drug baskets and dressing carts for refill the following morning.

DO WHAT THEY ARE ASKED

However, there is a long list of duties (too long to attempt to enumerate here) that they perform "as they are asked." There is a wealth of implication in that phrase. So much discussion has taken place in recent years about democratizing Uncle Sam's army that I have often wished it might be possible in some way to apply certain of our corpsmen's methods and procedures to the modus operandi of our armed forces. On the other hand, I would be the first to admit that this is probably wishful thinking and is only practical in dealing with a relatively small and fairly homogeneous group.

Nevertheless, after having been identified with the U.S. Army for almost twenty-four years (first in R.O.T.C. and then as a reserve officer), I am constantly amazed at the high level of performance of our corpsmen on *every* occasion despite the considerable degree of informality within the military pattern of their organization. They always have had an organization along military lines, with a captain at the head, a first lieutenant, second lieutenant, master sergeant, and so on down to "buck" privates. Yet, their relationships with each other and with the hospital staff are quite informal—but never disrespectful or to the point where the informality is detrimental to the performance of their duties. Their discipline is flawless, and yet one has to look carefully behind the scenes to detect it in operation. Prospective members are on probation long enough to permit careful observation. Those who don't "make the grade" simply are no longer included on the roster and quietly disappear from the scene.

When the USAAC disbanded in the latter part of 1945, the unit at Morristown Memorial unanimously responded to the hospital's appeal for continued assistance and reorganized immediately as the "Morristown Memorial Hospital Corps."

The plan of organization and operation has remained about the same, and the members have continued to use khaki uniforms furnished by the hospital. "Morristown Memorial Hospital Corps" is now worked into a special design for the shoulder patch on these uniforms; otherwise their dress is about the same.

One basic change under the new organization is that both the commissioned and noncommissioned officers are elected annually. The head of the corps is a captain. The first lieutenant is second in command and, in addition, is primarily responsible for the preparation and operation of the duty roster. The second lieutenant performs the duties of an adjutant. In addition, there are a master-sergeant (the secretary-treasurer) and a number of "non-coms" in the lower grades.

Membership of the corps totals between eighteen and twenty-four. It is a standing policy of the organization to keep the number between these limits. The reason for this is that with a larger membership the individuals are likely to lose proficiency and interest, whereas, with a smaller number, the assignments are too frequent and tiring.

Ages of the corpsmen range from 21 to 55. Besides meeting strict requirements as to character and physical condition, prospective members must have a New Jersey driver's permit. All members are given extensive and continuing training in first aid. Daytime occupations of the members range from office workers to garage mechanics, firemen, insurance salesmen, electricians and carpenters. One of the members is the mayor of Morris Plains, one of the municipalities principally served by the hospital.

The hospital furnishes the corpsmen with quarters (for the two on duty each night) and uniforms. In addition, the corpsmen and their families are covered by Blue Cross membership fully paid by the hospital. Also, the corpsmen themselves receive outpatient services (laboratory and x-ray, for example) without charge.

Benefits derived from the corpsmen's service are so extensive that the other members of Morristown Memorial's staff are hard put to find adequate ways to show appreciation. An annual dinner given jointly by the governing body and medical staff is one feature greatly enjoyed by all concerned. The donation of a small gift upon completion of 2000 hours of service has become another standing custom.

Local newspapers are always glad to get stories about the corpsmen and their accomplishments. A good example of this publicity is a recent story stating that the corpsmen had just completed 9300 hours of service for the year and pointing out that the numerous municipalities from which the corps draws its membership are indicative of the hospital's widespread service area. Also included were brief biographical sketches of two new members.

A recent story also prominently featured by the local press was headlined: "Firemen Not Only Fight Fires Here, They Also Help Memorial Hospital." The story went on to say: "It seems that a group of the 'smoke eaters' is making good use of their 'off' hours by assuming full responsibility both for the daytime operation of Memorial's two ambulances and for the maintenance of the vehicles."

FIREMEN ARE PROFESSIONALS

These firemen form the professional side of the team furnished by the local communities. The firemen are so accustomed to responding to calls in a hurry and keeping their equipment shipshape that they are ideally qualified for maintaining and driving the ambulances.

The arrangement for getting one of these daytime drivers is to telephone the Washington Engine Company, located only a few blocks from the hospital. At the fire house a roster is kept right up to the minute showing what fireman is off duty for fires but on duty for Morristown Memorial ambulance calls. The fireman on call for the hospital is always near the telephone, the number of which is on the roster at the fire house. As soon as this fireman gets a hospital call, he drives to the hospital, runs out the ambulance, picks up the intern and nurse, and is away in record time. Four minutes elapse, on the average, between the time that the hospital receives an emergency call and the time the ambulance gets away from the hospital.

Both groups of drivers pay strict attention to traffic regulations and always

follow the general rule of never driving in such a way that life may be endangered or property damage may ensue. It is second nature with every one of them to realize that it is sheer folly to risk additional lives through reckless driving in a supposed attempt to save the ambulance patient.

The firemen are not so numerous as the corpsmen. The number on the roster at the fire house usually fluctuates between six and eight. Of course, once in a long while the hospital will need a driver in the daytime when all the Morristown firemen are at a big fire. This occurred a few months ago during a two-alarm fire in a lumber yard not far from the hospital. When we called the Washington Engine Company we expected some delay but were pleasantly surprised to see two self assured drivers walk into the hospital in about the usual record time. One was an osteopath and the other a veterinarian, but they turned out to be accomplished ambulance drivers, despite never having reported for duty at the hospital before. What had happened, of course, was that the outlying fire company that was on call from Washington Engine Company was made up entirely of volunteer firemen, and the two who reported to us happened to be the next men "on call for Memorial Hospital."

Many hospitals have had experience with volunteer ambulance drivers. In view of this, and the fact that the principal advantages of having such a group are self evident, it would seem to be superfluous to summarize the outstanding benefits that Morristown Memorial has derived from the services of this fine organization of citizens from communities served by the hospital.

Insofar as the firemen are concerned, we are also specially privileged to have a hand picked group of citizens. The expense incurred in paying them so much per call (depending upon the length of run), plus what we pay two of them for maintenance service, is far less than what it would cost us for full-time employes to perform these services. Insofar as dependability is concerned, we'll vote for them in a minute in preference to full-time employes, no matter what the caliber of such employes might be. With the firemen at hand, vacation time, sick time, and personnel turnover never enter our picture, as *they* arrange these things among themselves.

There is a certain psychological advantage with respect to both groups. Although, within the hospital, they are certainly looked upon as integral units of the hospital family, it is evident that people outside the hospital consider them as definite community groups teamed together to extend the institution's vital emergency services to the community at large. Their value in thus linking this community hospital with the people it serves is an intangible advantage that we have learned to look upon with ever increasing respect.

INGREDIENTS FOR SAFE FORMULAS

Graduate nurse as supervisor—Dietitian as adviser

FLORENCE M. GIPE, R.N.

Director, Division of Nursing Education and Nursing Service
University of Maryland, Baltimore

THE problem of formula room management is one that must be faced by every hospital administrator, every director of a school of nursing, and every instructor in that school. The problem is a joint one of hospital service and a teaching situation within the same area.

For some time there has been quite an extended controversy among hospital superintendents and directors of nursing education whether the supervisor of this department should be a registered nurse or a dietetic teacher. There are at present three schools of thought on this important problem, namely:

1. Those who believe the supervisor should be a nutritionist or a dietitian.
2. Those who believe that a graduate registered nurse should be the directing head.
3. Those who believe that the directing head should be a graduate registered nurse well informed in the field of microbiology and skillful in surgical technic; that she should be as competent as an operating room nurse. In addition to the graduate nurse, a dietitian should advise when necessary.

Having had a great deal of administrative experience and extended interest in this field, I feel that the third choice presents the most logical approach. In considering this important phase of hospital management and teaching responsibility, one must take as his first premise that the milk laboratory is as important as the operating room. It has not received this recognition in the past.

The directing head should be carefully chosen as to knowledge, skill and experience; she should possess sound teaching attributes, be skillful in handling sterile materials, insist upon valid principles of microbiology and upon exactitude. She should also have keen ability to recognize broken technic.

Upon investigating and comparing the two curriculums of the graduate nurse and the dietitian, one finds that both contain subject material which is necessary to carry out the desired objectives. But is the necessary experience in applying this knowledge and managing necessary skills gained until by repetition they become fixed habits? As to the graduate nurse who has had an extended operating room experience, who has been taught to make critical observation, who has knowledge of disease producing organisms, and has followed Dewey's law for learning whereby the student "learns to do by doing," one can be fairly sure that her technic will be sound. Her knowledge of food and nutrition may not be so extensive as is the dietitian's, but she follows the prescription of the pediatrist.

The dietitian gains a knowledge of bacteriology in her college program, and through demonstration she learns to manipulate sterile materials. There is no question about her knowledge of chemistry and nutrition, but the fact remains that she has not had the opportunity to be watched in an operating

The sterile nurse pours the formulas into the bottles, caps them and passes them to the student who places them in the milk sterilizer.

room or other situations by critical observers until these laws become fixed to the point of a natural habit. If she could have several months of practice in these aseptic principles, there would be no question as to her superior preparation for the position, but few, if any, dietitians really plan their course for a major in formula preparation.

Often the dietitian directs a student nurse by merely paying a visit to the formula room. How utterly ridiculous it seems to expect students who are learning to be responsible for this procedure! Would we place the construction of our million dollar buildings under the direction of a student architect?

NO CONTACT WITH PATIENTS

A graduate nurse assigned in charge of the formula room should have no contact with patients and neither should the students. Often one hears of a head nurse in the maternity department directing the formula room, while within the same division her other duties require the carrying of bedpans, diapering babies, and changing perineal dressings. She should, if the position does not demand her full time, be assigned to secretarial work or to relieve in the nursing school office when she is not on duty in the formula room. Students should never be allowed to come in contact with patients or other nurses working in infectious areas. Through careful teaching, this principle of extreme caution has far reaching importance.

The University of Maryland Hospital, like many large medical centers, had some trying experiences during the war with infectious diarrhea. A dietitian supervised the formula room at that time. She paid short daily visits to the department and observed students for a brief period; she then followed out other assignments. The situation presented itself as a serious nursing problem, and indeed it was. It required the immediate attention of the administrative group. A special committee was formed to study the problem and to select a formula room team to carry out the plans. The following composed the personnel of the team:

1. A graduate, registered nurse with a college background who possessed special aptitude for aseptic technic. The operating room supervisor made the recommendation. This nurse was to be in charge of the department and also to be instructor of students.

2. A teaching dietitian as consultant in regard to the mixing and timing of all unfamiliar combinations and ingredients.

3. Two student nurses to obtain a week's formula room experience, writing case assignments and doing library research.

4. One maid to wash all soiled bottles and cooking utensils and to transport materials to sterilizing room for autoclaving.

The technic is as follows:

In a separate kitchen a nurse's aide cleanses and packs for autoclaving all utensils, such as bottles, pans, dishes and spoons. After they have been sterilized for the required time she removes them on a carrier and returns them to the formula room for use the following day.

The head nurse and student nurse prepare a sterile table about 4 feet long and 2 feet wide. The scrub nurse wears a sterile cap, mask, gown and gloves, while the other nurses wear unsterile attire. The sterile nurse handles all sterile materials; she pours the formulas into the bottles, caps them and passes them to the student who functions as a float nurse.

The float nurse places them in the regular milk sterilizer where they remain for five minutes under 15 pounds' pressure at 240° F. After sterilization takes place the bottles are carefully cooled, marked and placed in the refrigerator. Twice each week a laboratory technician makes a culture on formulas that are twelve hours old and issues reports to the obstetrical department where the chief of the division, the resident, interns and graduate and student nurses read them to discover any evidence of bacterial growth.

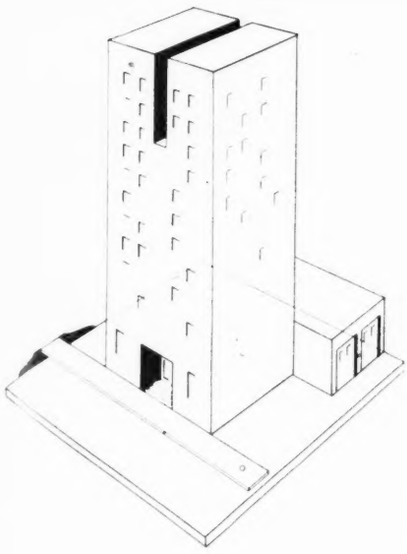
FIFTY FORMULAS PER DAY

Before the student is assigned to the department she is asked to pay special attention to the shampooing of her hair, the filing of her nails, and strict hygienic care of her body and uniforms; she is not permitted to go into any other department in the hospital, or get in close contact with nurses who are caring for infectious cases. The department averages approximately 50 formulas daily; therefore, the student nurses and the head nurse have enough duties to require their full time.

One may think that the table technic and the milk sterilizer are duplicating sterilization. If the one method is sound, why use the other? The answer is this:

1. No institution can afford to take the chance when provision has been made to guard against infection by supplying modern equipment.

2. If we teach the student to use only the metal sterilizer, she may later be employed in an institution that does not possess this piece of equipment, or she may not know the simple table technic that can be used in the home or in any situation. At any rate, the present method has brought good results so far. The University of Maryland Hospital has prepared more than 36,500 formulas within the last two years, and it has had no repetition of the former difficulty.



THE FUNCTIONAL BASIS

OF HOSPITAL PLANNING

CONSTRUCTION MATERIALS and FINISHES

Continuing a Study by the
Division of Hospital Facilities
United States Public Health Service

THE hospital is unusual and different from other types of building projects in that its annual maintenance and operations budget will be approximately one-third to one-half of its original construction cost. It is important, therefore, that careful consideration be given those factors in construction that affect these costs. The types of construction materials and finishes which are incorporated in the hospital structure will have a considerable influence on such items as repairs and repainting; insurance, depreciation and obsolescence are closely related to construction details. To minimize operation costs, such factors as heat or cold insulation and sanitary finishes must be closely evaluated when a construction outline is prepared.

It is important that the designer provide as quiet a building as possible in order to facilitate the treatment and recovery of the patients. Objectionable noises may result from several causes, including unsatisfactory construction, poorly adjusted mechanical equipment, and inefficient operation. Common sources of annoyance include poorly controlled doors with clicking and chattering hardware, noisy windows, high velocity water to plumbing fixtures, such as bedpan washers and toilets, raucous call systems, water hammer in steam heating systems, humming motors, compressor vibrations, and noisy electrical switches.

Much of this noise can be abolished by properly selected equipment, correct installations, and prudent maintenance. Inasmuch as it is impossible to eliminate all noise, acoustical finishes should be utilized whenever possible in order to minimize the transfer of noise. Rooms which house mechanical equipment that may be a source of noise should have ceilings, walls and, if possible, floors treated with an acoustical absorbing material.

The following discussion will present the elements which should receive special consideration in order to facilitate the daily work and maintenance throughout the hospital.

WALL SURFACES

Ordinarily, the typical interior wall surface of a hospital consists of a hard plaster finish with all external angles protected by metal corner beads. The walls should be protected by at least a three-coat finish of flat oil paint, flat enamel, or washable wall covering suitable for frequent washing. The judicious use of color is recommended for its beneficial effect on both patients and staff. Operating rooms, delivery rooms, sterilizing rooms, dishwashing rooms, and other rooms in which excessive splashing and dampness occur should have a glazed tile wainscoting or other type of moisture resistant surface to a minimum height of 5 feet.

Around sinks and baths and in utility rooms, where splashing and dampness are limited to small areas, these areas should be protected by glazed tile, linoleum or other moisture resistant materials. For sanitary reasons, ease of cleaning, and durability, the kitchens, pantries and walk-in refrigerators should have moisture and stain resistant walls, preferably of glazed tile or other masonry units laid in acid resisting mortar.

FLOOR SURFACES

Floor surfaces should be selected for durability, economy of maintenance, and utility. For offices, patients' rooms, treatment rooms, patients' corridors, laboratories, workrooms and solariums or day rooms, the use of linoleum, rubber tile, and asphalt tile is suggested to provide greater comfort and resiliency. Bathrooms, toilets, showers, hydrotherapy rooms, utility rooms, serving kitchens, and cafeterias should have terrazzo, ceramic tile, or other types of floors with similar characteristics.

Quarry tile laid with a greaseproof, acid resisting mortar is recommended for kitchens, refrigerator rooms, and other food preparation rooms. Operating, delivery and emergency suites should have ceramic tile, terrazzo or plastic floors which have been made electrically conductive in accordance with the recommendations of the National Fire Protection Association.

Wear resistant, nonskid and easily cleaned surfaces are required for public corridors, lobbies, stair halls, and other heavily traveled sections of the hospital. Terrazzo floors have been found generally suitable for these areas. Coved bases are indispensable for ease in cleaning.

CEILING SURFACES

The ceiling construction throughout a large portion of the hospital will generally consist of a hard plaster finish protected with an oil or enamel paint as specified for walls. Certain areas of the hospital that are considered to be the greatest sources of noise should have ceilings surfaced with a sanitary covering designed to control, absorb or otherwise reduce the effect of noise. These include such rooms as nurses' stations, utility rooms, floor pantries, nurseries, labor rooms, dishwashing rooms, dining rooms, solariums, patients' corridors, entrance lobby, and waiting rooms. Since the floors and walls of these areas must be durable and wear resistant, the ceilings are the only remaining surfaces that can be used to provide some measure of acoustical comfort.

Certain types of floor construction, notably those involving thin, dense structural materials, are capable of readily transmitting noises to occupied areas below. It is desirable to provide a ceiling construction with adequate acoustical properties to muffle and to absorb such noises.

CEILING HEIGHTS

To provide maximum comfort and optimum working conditions in the kitchen and laundry, a ceiling height of 12 feet is recommended. The heights of boiler rooms and workrooms will be governed by the type and size of equipment to be installed. All other areas in the hospital should have 9 foot 6 inch ceilings except corridors, storage closets, and minor auxiliary rooms, which may have somewhat lower ceilings.

CORRIDORS

Normally, corridor widths should be maintained at 8 feet with an increased width provided at elevator lobbies and other places where complicated traffic conditions may demand more clearance. For durability and reduced maintenance costs, glazed wall units have been successfully utilized for the walls of corridors and stairwells. Provision should be made in the ceiling construction for the flush type of ceiling fixtures recommended for corridor use. Flush nightlights are also desirable in the corridor walls and should be located approximately 18 inches above the floor and about 40 feet apart.

DOORS

For ease of maintenance and sanitary appearance, interior doors should be of the flush panel type. Heavy wood doors are considered satisfactory if they are treated to retard the spread of fire. The recommended width of doors for patients' use is 3 feet 10 inches, with a minimum of 3 feet 8 inches. Door trim should be kept simple in detail, set flush with plaster, and should preferably be of metal construction. Substantially heavier door frames are required where friction hinges are used.

Double acting doors should be provided into utility rooms, workrooms, kitchens and similar areas. They should be swung so that the back of the door rather than the edge faces anyone walking down the right side of the corridor. These doors should have vision panels and should be equipped with push plates and kick plates on both sides.

When required for complete ray protection, doors in radiographic suites should have suitable lead shields. Door openings and pass windows leading to darkrooms or rooms where fluoroscopic work will be done should be made light-tight.

HARDWARE

Hardware for hospital use should be selected for service and appearance, as well as to ensure quietness and sanitation. Doors to patients' rooms should be equipped with friction hinges, friction slides, or a combined door check and holder in order to prevent door slamming and to permit the door being left open in any position for ventilation. Arm hooks used with roller catches are recommended for opening all single doors in patients' areas as door knobs are considered insanitary and difficult to use when one is carrying articles. Only the quietest doors and door-opening mechanisms should be considered for elevator installations.

Offices, storage rooms, and closets should be provided with cylinder locks. Other locks may be required at certain supply cabinets, drawers and drug cabinets at the nurses' station, in the laboratory room, or in other work areas.

It is not necessary to provide locks on doors to bedrooms or wards except in psychiatric units. However, it may be desirable to provide dead locks for locking the doors when the rooms are not in use. Floors, wings, departments and sections should be similarly keyed or master keyed to eliminate the need for a large number of keys.

WINDOWS

The size, type and number of windows are closely related to problems of lighting, heating, ventilation and mechanical and structural details. For optimum lighting and ventilation, the window opening should be located as near the ceiling level as possible. Multiple glazing should be used in operating suites, nurseries and all other air conditioned areas to prevent condensation as well as to reduce heat losses. Double glazing throughout will make substantial savings in fuel and will add greatly to the comfort of the patient.

Operating rooms, delivery rooms, examination and treatment rooms, toilets and bathrooms may require glazing with obscure glass to ensure privacy. Removable storm sash is subject to handling and storage difficulties and is recommended only for extreme winter exposures. Where openings must be made secure and safe from inside tampering, as in certain rooms of psychiatric units, detention screens are recommended, placed flush with the interior face of the wall openings. Lightproof window shades are necessary for the fluoroscopy room, darkroom, eye examination room, cystoscopy room, and at least one operating room.

LINEN CHUTES

The use of linen chutes in hospitals is a somewhat controversial subject. The convenience, utility and speed must be balanced against the possibility of fires (which may be started by lighted cigarets discarded down the chute) and the difficulty in maintaining a clean chute.

When used, linen chutes should be located for convenience of access from all parts of the nursing units and preferably off a subcorridor or in a closet. The recommended interior diameter is 24 inches, with access doors located approximately 36 inches above the floor. Glass-lined metal or a rustless material should be used for the chute lining. Provision for cleaning the chute should be made at each access door; a hose spray has been utilized in several instances, with a hot water or steam connection at each access door. A suitable drain should be installed at the bottom of the chute, and a small ventilator opening at the top.

WORK COUNTERS

To provide the maximum storage space in an orderly manner, it is desirable to furnish as many cabinets, drawers and open shelves below and above work counters as possible. Drawers should be fitted with quiet-operating channel or ball-bearing supports and guides. Metal doors should be of the hollow type, filled with sound absorbing insulation. Movable shelves will permit adjustments to accommodate

varying sizes of utensils and will also facilitate cleaning the interior surfaces of the cabinets. The edges of metal shelves should be rolled at the front and turned up at the rear. Stainless metal shelves are recommended as being more durable, sanitary and easier to keep clean.

The duties and functions which are to be performed at the various work counters must be carefully studied to determine suitable dimensions, design, material, finishes, and coordination with other equipment and fixtures. Toe space should be provided below all work counters. Cabinet bases should be grouted to the floor or integrally fitted with floor finish to prevent the entry of water or vermin. Counters, counter backs, and cabinets should be tightly fitted against the wall or built into the wall for similar reasons.

The underside of metal counters should either be treated with a heavy coat of cork impregnated paint or have a suitable felt-base material cemented to the metal for sound-deadening reasons. The information counter in the main lobby should have a linoleum or glass surface and should be provided with suitable shelves and drawers to accommodate the necessary directories, literature and similar supplies incidental to the duties of telephone and information service.

Work space in utility rooms, floor pantries, nurseries, flower rooms, and other nurses' work areas should preferably have stainless metal counter tops approximately 20 inches wide and 36 inches above the floor. These tops should have welded and smoothly ground joints, rounded corners, coved intersections, and integral backs to protect walls. Dishwashers, hot plates, and other equipment may be built integrally with such metal tops.

Counter tops in laboratories should be soapstone or similar material, wood (birch which has been acidproofed), asbestos or heavy battleship linoleum. Counters should be substantially made to provide a firm base for the use of microscopes, centrifuges, scales and chemical apparatus. Provision should be made for water, gas, vacuum, air and electrical connections in the counter backs.

Storage cabinets, drawers and shelves are required both above and below the counters for chemicals, glassware, small apparatus, and supplies. Peg boards should be provided for drying glassware. Fume hoods may be required in the chemical laboratory and must be vented through the roof with an acid-resistive exhaust fan and duct. Acid-resisting sinks, traps and drains should be provided in laboratories.

Counter tops in x-ray darkrooms should have surfaces of linoleum or other smooth materials. The cabinets below should be arranged with storage space, separate vertical compartments for holding different sizes of cassettes, space for storing film hangers, and a lightproof film storage bin. The film storage bin should be lead lined unless the entire darkroom is protected. Frequently, a special switch is provided which will turn off the white light when the bin is opened.

Instrument cabinets in smaller hospitals may be located in the operating room, delivery room, or adjacent corridor, but the larger hospitals should have separate and individual instrument rooms. Instrument cabinets should have glazed dust tight doors. Adjustable glass shelves with a 1 inch space between the shelves and the back of the cabinet to permit air circulation are desirable.

It may also be necessary to provide separate locked sections for the storage of the individual surgeon's instruments. Pharmacy cabinets should be arranged to store many small items of varying sizes in an easily accessible manner. Cabinets designed for such use are available from several commercial equipment manufacturers.

BULLETIN BOARDS

Bulletin boards should be freely used throughout the hospital to advise the professional and operating personnel of daily schedules, staff information, and other pertinent announcements. Information for patients and visitors may also be carried on certain boards. In most locations, a framed, cloth covered, cork or other type of board, approximately 24 by 26 inches in size, will suffice.

Bulletin boards should be placed in the following locations: waiting rooms, offices, library and conference rooms, lounges, treatment rooms, isolation rooms, nurses' stations, utility rooms, surgical and obstetrical suites, workrooms, sterilizing rooms, nursery areas, laboratories, radiology rooms, pharmacies, emergency rooms, kitchens, floor pantries, formula rooms, storage areas, and boiler rooms.

Health centers and community clinics should be amply provided with suitable display space for educational material.

Now They Come at Eight

A Change We Hope You'll Like!

It's been the rule in ages past
To start the day at Seven.
This kept the nurses working fast
Sometimes until Eleven.
To let you sleep an hour more
We now will come at Eight.
We'll have more help 'til half past Four
We know you'll think it's great.

FOLLOWING a public opinion poll in the Twin Cities by Mrs. Margaret Randall of the University of Minnesota, it was found that patients felt that 7 a.m. was too early to be awakened. Since our operating room schedule was built on the 8 o'clock day, the doctors, nurses and the administrative staff set Monday, Nov. 10, 1947, as a "red letter day" at Northwestern Hospital.

The poem, written by one of the nurses, was printed and passed to each patient in the hospital with an explanation: "Your day nurses will appear at 8 a.m.! But will be with you until 4:30 p.m. By doing this we hope to give you better care throughout the day by having the nurses on duty when you need them most. (Your afternoon nurses will then be on duty until 12 midnight; your night nurses from 12 to 8 a.m.)

"We sincerely believe it will mean a happier Northwestern 'family'—doctors, nurses, patients, everyone!"

Our expectations have been more than fulfilled. The patients are happier. The doctors cooperated beautifully and have registered no complaints, and the hospital personnel definitely likes the change. Why don't you try it?—RUSSELL C. NYE, *administrator, Northwestern Hospital, Minneapolis.*

THE PICTURE OF HAPPINESS

EDWARD J. MILSOM
Assistant Administrator
Garfield Memorial Hospital
Washington, D.C.

ONLY three days old—and the spittin' image of his father. Daddy can look at Junior through the big glass window, but the camera can beat him to it! Through a new service in operation at Garfield Memorial Hospital, Washington, D.C., photographs are taken of brand new babies right in their cribs.

Every new thing has a history and background, and the taking of new-born babies' photographs is no different from any other new venture. Back in 1941 Robert Clark, a young reporter and photographer of the *Washington Times-Herald*, became interested in baby photography when a child was born in his own family.

The war came along and Mr. Clark had to lay aside his hobby to enter the service. At the close of the war he again took up his hobby, and with the purchase from War Assets Administration of a number of airplane cameras and a special synchronized speed-lamp he designed and patented a photography unit.

The camera and lamp are attached to an upright metal standard at a set height and set focus. The lamp has a life of approximately 10,000 flashes.

In each nursery a complete photography unit is permanently installed. Garfield has six regular nurseries, a two-room premature unit and a four-room isolation unit.

Every second day the head nursery supervisor, in making her rounds, takes the pictures of all new-born babies in each nursery.

The baby's family name and mother's admission number and the date are printed on a card on which is imprinted the name of the hospital by the nurse in charge of the nursery. With the baby lying face upward or slightly to one side, this card is placed over his knees. The nurse pushes the bassinet under the camera, presses a push button on the floor with her foot and returns the bassinet to its original location. All nurseries can thus be served by one person in a short time.

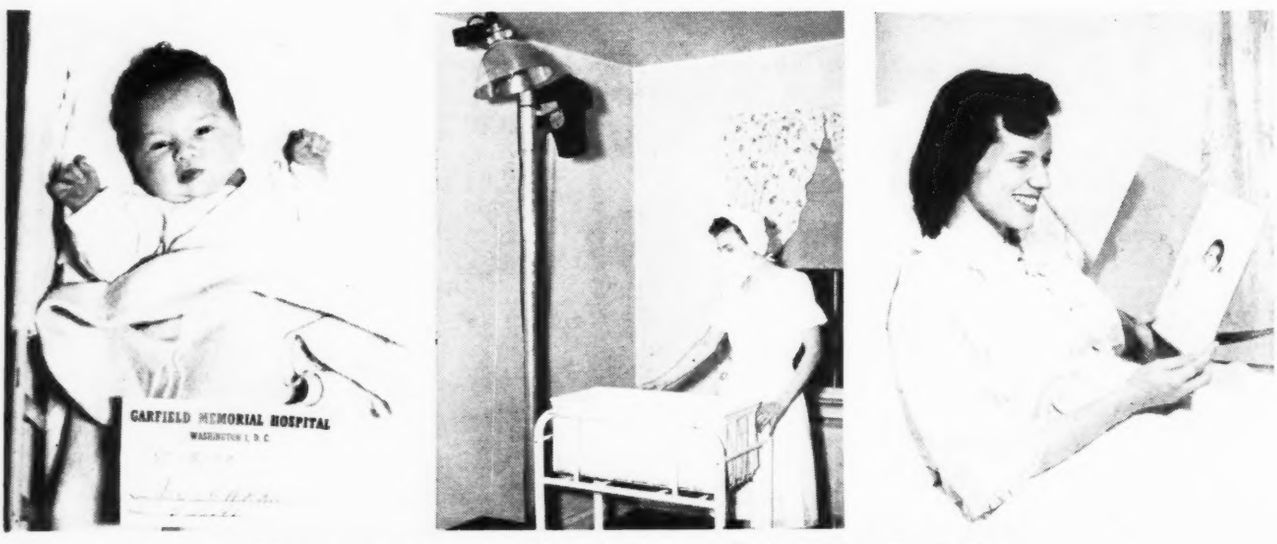
A representative of the picture service reports to the nurseries every other day to remove the used films from the camera and to reload for the next day's use. These films are taken to the laboratory for processing and printing. The person who enters the nurseries is gowned, capped and masked properly for this work so that the risk of transmitting air-borne germs is reduced to a minimum.

A picture of each baby is taken routinely in this hospital as a mandatory identification required by the board of directors. Premature infants and those in isolation have their pictures taken at the time they are considered normal.

The identification picture is 2½ by 3½ inches and is attached to the baby's admission card for permanent record. Another picture 4½ by 6½ inches is placed in a folder 6½ by 9½ inches. This picture is delivered to the mother by the secretary of the hospital record department in charge of baby records at the time of presentation of the hospital birth certificate. If the mother desires to keep the picture a charge slip is made out and sent to the business office and entered on her account. Approximately 97 per cent of the mothers keep the pictures.

Attached to the picture is an addressed card which the mother may use to reorder additional copies of the picture or small birth announcement pictures. These orders are handled by mail between the picture service and the family.

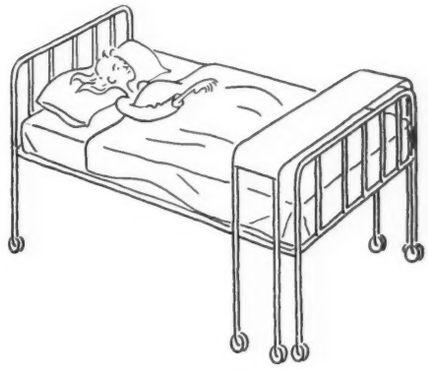
The surprise, and then the glow of happiness that radiates in the face of the mother when she sees the picture of her new-born child, is another picture worth seeing. One cannot help but be happy in seeing the happiness of the mother, and the hospital recognizes that this is an excellent public relations medium.



Three steps to good public relations: 1. Baby in his crib. 2. Nurse takes picture of baby. 3. Mother happily admires picture of baby.

THE *Person* AS A *Patient*

FLORENCE C. KEMPF
Assistant Director of Nursing Service
University Hospitals
Cleveland



IN HOSPITALS, the *person as a patient* has often had to give way to the *patient as a person*. On first reading, this sentence may suggest a play on words; it urges, however, a broader emphasis, in our care of patients, on the study of persons, and it emphasizes the logical sequence of study which should underlie our approach to the individual who needs medical and nursing care.

Once the word "patient" registers in the minds of the nurses and doctors, their thoughts immediately turn to illness because education and practice have cemented association of the terms. When attention is focused on signs and symptoms of illness and on nursing skills and treatments, the person as a *person* usually receives secondary consideration. Although schools of nursing have taught that nursing care must be given to the whole person, we have more often demonstrated the findings, treatment and care determined by the disease.

Granting that these are important, primary attention to them becomes an obstacle to understanding "all that the person is or hopes to be" and to supplying the modifications of care that each person requires. There are still nurses and doctors who believe that teaching maintenance of health and prevention of disease belongs in the province of public health workers alone, rather than being an essential skill in all medical and nursing care.

It seems important, then, that more effort be made to develop a concept of the individuals under our care as *persons*, with all the facets of personality and character which make them interesting people, and which determine their needs for hospital care and health instruction. With this concept, the nurse can better help individuals to adjust to the discomforts, inconveniences, pain and fears associated with illness, and it would seem that the doctor would be more likely to uncover psychosomatic factors that complicate recovery.

If nurses can learn to direct attention and thought first to understanding the personalities before them and then to adapting their nursing care to the needs of these persons, more intelligent nursing should result, and the patients will be better informed on self-care for recovery and well-being upon discharge.

With the increased emphasis in the thinking of both the public and the hospitals on the individualization of medical care, it seems timely to consider ways in which total patient care may become more satisfactory.

In teaching psychology in schools of nursing during the last twenty years, I have reached the conclusion that an outline to guide the nurse's approach to the study of persons has value. An outline follows with pertinent comments that have been gleaned in the years of teaching of student nurses. Since graduate nurses are just as vitally concerned and even more responsible it is hoped the outline may prove of interest and be considered worthy as a guide for necessary study of persons in determining their nursing needs.

AS A PERSON

Name. Her *name* may be Gillooley, Jones, Sikorsky, Cohen, Arsenian or Schneider. Names are important to people. Correct spelling and pronunciation of a person's name are courtesies that are every person's due. Names used to suggest nationality origins but can no longer be entirely relied upon for this knowledge. The use of first names or nicknames suggests undue familiarity but is encouraged in the care of children.

Age. Her *age* may be anywhere between 18 and 80, or below or above. Planned health instruction is an important part of the care of younger people. Recognition should be given to the wisdom which older people have acquired in living, even when it does not relate to health maintenance.

Appearance. She may be short or tall, dark or fair, attractive or plain. She may select and wear her clothes well or otherwise. It is her appearance which may first attract, repel or cause people to be indifferent to her. Their reactions often determine the self assurance the person develops.

Heritage. She may have a stable or a volatile nervous system. She may be dull, average or superior in her ability to learn; perhaps she was always at the head of her class in school, or she may have found herself in the bottom ten.

Basic Needs. She is like the rest of us in her needs for food, shelter and clothing, and in her desire for recognition, respect and affection. She is also different from everyone else in the world be-

cause of the genes combination, determined by heredity, and of the environmental facts of education and experience.

Native Drives. Her urge to dominate persons and situations may make her a leader or a person who has come into frequent conflict with others. On the other hand, she may be timid and in need of encouragement. Her desire to be with her own kind may prove an asset or a handicap to her accomplishments. She may still require assistance in her development of self-control.

Environment. Her family may have been citizens of this country for five or six generations, or perhaps she only arrived in the United States ten years ago and still feels insecure in our culture. She may have a language handicap that increases the need for tact and understanding.

Home. She may have brothers and sisters whom she loves or dislikes, parents who were interested in her or neglected her. She may have a husband and children who constitute her major interest in life or whom she considers a burden. Economic problems may nag many of her waking hours.

School. She may have had fine educational opportunities or have had to struggle for an eighth-grade education. Her teachers may have been stimulating, or they may have been warped unhappy people who have unfavorably influenced the development of this individual's personality.

Community. She may have grown up in a residential village where she knew everyone, or in the city where acquaintances were limited; perhaps she has always lived on a farm. She may come from a progressive, economically secure community or from the city slums.

Church. She may have complete faith in her God or have no spiritual strength to support and comfort her.

Occupation. She may have a good position with adequate salary; she may be out of a job or, because of poor preparation, disposition or health, be unable to hold a job. Perhaps she never has worked or has forgotten how to play.

Temperament. She may be a friendly, optimistic, generous person who cooperates and helps people because she likes them; on the other hand, she may be self-centered and seek only her own gain. She may be a chronic complainer who will require guidance to see the good.

The habitual reactions of this person are dependent on all the factors discussed and on additional ones that will come to light in the study of the total person. The nurse must consider all this knowledge of the person and use it not only in planning care but also in facilitating the necessary mutual adjustments that sickness necessitates.

AS A PATIENT

Illness. Signs and symptoms have developed that will be diagnosed. For the time being, the person becomes a patient. Her adjustment to this illness and hospital experience will be determined not only by existing habit patterns but also by previous experience and knowledge of nurses, doctors and hospitals.

Individual feelings of adequacy may undergo a "shrinking" process when the person is dressed in a hospital gown and tucked into a hospital bed. Outward poise may not vanish completely, but the premise that all patients are insecure, regardless of behavior, is a relatively reasonable and helpful one to assume. The understanding and care that this patient and her relatives receive will determine her eventual attitude toward the illness as well as toward nurses and hospitals.

Approach to and Care of the Patient. The principle of likenesses in all people must serve as the basis for understanding—differences in degree should be expected. Introduction of yourself and of other employes who enter the unit, as well as those who are bed neighbors, is important. Orientation of the person to her new surroundings should include a demonstration of physical facilities necessary in care, something about how they work, assurance of their harmlessness, or cautions about using them if there are related hazards.

It is unlikely that the nurse, on first meeting the patient, will have all the knowledge about the person that has just been proposed as desirable. However, just as her observations about illness must be accompanied by a knowledge of what to look for, so in her developing acquaintance with the person she must have the sensitivity to recognize, interpret, use and report the personal findings.

Adjustments of the Patient. Many persons are reluctant to have physical examinations. If the nurse interprets the physical examination so the patient understands that it is carried out to determine not only what is wrong but also what is right and stresses prevention as well as correction, the patient may feel reassured. Explanation of technical terms when possible is desirable; if inadvisable, then avoidance of the use of them in the presence of the patient is a kindness.

Procedures and the purpose of treatments should be explained before they are initiated; if there will be pain associated with them, the patient should be told, but without undue emphasis, and she should be assured that the nurse will be careful and gentle. The patient who has something to hold or watch may find this diverting so that discomfort becomes more endurable. When surgical intervention is necessary, the patient should be told about the cooperation that will be needed from her postoperatively for best results.

All patients have fears. Through her knowledge of the *person* and of her past experience, the nurse can determine what will be most helpful in lessening these anxieties. Associated with the fear of the diagnosis are many other apprehensions that may haunt the person in bed: fear of "needles," of "cutting," of deformity, of crippling and helplessness, of unemployability and becoming a burden, of suffering and pain, of incurable disease which may be interpreted as personal or family disgrace, of losing loved ones, and of death.

The nurse must be a person who encourages and merits confidence so that the patient may put her fears into words; sharing them may bring some relief. Some of these fears should be relayed to the head nurse, and some to the physician. Social service personnel and occupational therapists are available in many hospitals and are most helpful. Religious advisers may bring comfort and sustain courage.

Informing the family about the attitudes that would be most comforting to the patient may produce relief. The knowledge that loved ones understand and care and need her may encourage effort and hope for recovery by the patient when all else fails.

When the sick person's condition permits, it is advisable to find interests and diversions so that she can be helped to forget herself in them. If there is something she can do for others, so much the better, and the nurse should give guidance in such projects. The patient's faith must be built up—and sustained—in the nurses, the doctors, and the hospital. As her fears are relieved by knowledge and as her security is assured by understanding and love, physical recovery will also be accelerated. Illness gives way to health, and the person as a patient again becomes self-assured.

And Always Teach. Nursing the person as a patient includes teaching the

importance of regular checkup and treatment and the value of good supportive measures, such as nutrition, rest, air and sunshine, and consistent habits of personal care. In many cases reeducation may be necessary. The needs of the person and the long-time value of what is included in the nursing and teaching plan must always be considered. Regardless of whether the person is generally intelligent and well informed, or completely the reverse, there is always a great challenge to the nurse's powers to relieve mental anguish and to meet every need of every person.

Nursing persons as patients demands from nurses qualities and abilities such as John Dewey had in mind for physicians when he said:

"Just in the degree in which a physician is an artist in his work he uses his science, no matter how extensive and accurate, to furnish him with tools of inquiry into the individual case and with methods of forecasting a method of dealing with it. Just in the degree in which, no matter how great his training, he subordinates the individual case to some classification of disease and some generic rule of treatment, he sinks to the level of the routine mechanic. His intelligence and his action become rigid, dogmatic instead of free and flexible."

Fifty years ago, doctors knew their patients as people, often from birth and through several family generations. The "family doctor" served in the capacity of friend, physician, psychiatrist, dietitian, therapist. He guided the nursing care and gave instructions contributing to the recovery of health. He did not require a social worker because he knew the social and economic problems of the people in his community.

Today, with the centralization of population and the advances of science, specialization of responsibility represents a necessary adjustment; the doctor now has become a captain of a team—he still decides what the person as a patient requires for recovery and maintenance of health. He can do this effectively to the degree that each of the members of his team keeps him informed of findings and contributions to the total care. The nurse holds the key position of having more opportunity to learn to know the person; her alert and informed intelligence should enable her to make many observations which, relayed to and discussed with the physicians, should lead to a plan of medical and nusing care which would achieve the maximum in patient care, our common goal.

The total care of patients requires intelligent insight into human nature, accompanied by patience and diligence in making effective use of this insight. The nurse's attitude toward the "person as a patient" should reflect her liking for people, her respect for the dignity of the person with a soul as well as a body, and her sincere desire to serve.

Procedures for Recruiting Nurses for Polio Cases

IN THE event of an increase of infantile paralysis cases requiring the recruitment of additional nursing personnel, the local chapter of the American Red Cross will recruit nurses upon receipt of a written request form entitled "Request for Nurses," signed by the administrator of the hospital where the nurses are to be employed. Five copies of the form must be filled out by the hospital administrator and forwarded to the local chapter of the National Foundation for Infantile Paralysis for approval.

If it is possible for the hospital to increase its nursing personnel at the regular institutional salary, additional nurses should be employed with the understanding that the National Foundation's chapter will underwrite the salary, provided such personnel is to be used to supplement, but not to replace, the normal complement of nursing personnel for polio patients.

When the hospital administrator cannot, through regular employment channels, fill the nursing needs for polio patients at the regular institutional salary rate, all additional temporary nursing personnel for polio patients must be obtained through Red Cross recruitment at the designated national salary rate.

Registered nurses with previous polio nursing experience or special training in the care of polio patients will be recruited. Nurses without polio experience or training will be recruited only after the experienced people are no longer available.

Nurses recruited by the American Red Cross for polio nursing will become employes of the hospital or institution for which they are recruited. The National Foundation's chapters are authorized to reimburse the hospital or institution for the nurses' salaries.

A nationally uniform monthly basic salary of $250 will be paid to all nurses, except supervisors, for not less than forty hours and not more than forty-eight hours' duty per week. A salary of $275 will be paid to supervisors.

Local nurses recruited by the Red Cross for polio nursing will receive the basic salary of $250 per month. It is understood that they will pay for any maintenance received at the institution unless the institution wishes to furnish such maintenance without charge. To nurses recruited outside the community, maintenance, to include lodging, meals and laundry of uniforms, will be made available by the hospital if at all possible.

The National Foundation's chapters are authorized to reimburse the hospital or institution for the actual cost of such maintenance but not to exceed $75 per month.

When maintenance cannot be provided by the hospital or institution to nurses recruited outside the community, an allowance of $75 per month, to be applied toward maintenance, will be paid to each nurse by the hospital or institution as partial compensation for living away from home. The National Foundation's chapters are authorized to reimburse the hospital or institution for this monthly maintenance allowance.

Travel expense from the place of recruitment to the place of assignment will be paid by the local chapter of the American Red Cross which recruits the nurses. Return travel expense from the place of assignment to the place of recruitment will be paid by the local chapter of the Red Cross at the place of assignment.

Condensed from the statement of procedures adopted by the American National Red Cross and the National Foundation for Infantile Paralysis.

ISOLATION UNIT OFFERS PROTECTION

CHARLES S. PAXSON JR.

Superintendent, Delaware County Hospital, Drexel Hill, Pa.

FOR many years the 350,000 people of Delaware County, Pennsylvania, have been without adequate hospital protection for the care of patients suffering with communicable diseases.

After a thorough study of the problem, it was deemed advisable to supervise admissions carefully and to restrict them to those cases that required hospitalization either because of the severity of the disease, because there were medical or surgical complications, or because home conditions did not permit adequate quarantine for the protection of the public health. With this policy established, reasonably small units could be constructed that would adequately take care of such a closely defined communicable disease case load.

In the preliminary stages of planning, it was obvious that several types of diseases would be treated in the unit at the same time. Therefore, the planning of the building was around the isolation of each individual patient rather than the isolation of the various types of diseases. From the accompanying floor plan it will be noted that each patient is cared for in a separate cubicle or room, which is, in most instances, constructed with metal and glass partitions from floor to ceiling. This type of partition provides maximum nursing supervision of the children and affords an opportunity for them to enjoy one another's company while isolated by glass. Children will comprise between 80 and 85 per cent of the contemplated case load.

A rigid aseptic technic was developed providing separate gowns and scrub facilities for each patient's cubicle. Ultraviolet lights have been installed in the corridor.

The unit was designed to be as self sufficient as possible, with facilities to dispose of trash and combustible materials, as well as of waste food. The food is delivered in bulk containers to the diet kitchen from which it is served to the patients. The bulk containers are the only dietary items that are returned to the kitchen after sterilization.

Provision was made for the handling of laundry in two ways. The first is the dry routine procedure, and the second, the chemical soak, which is given to all linens before they are sent to the laundry for routine processing.

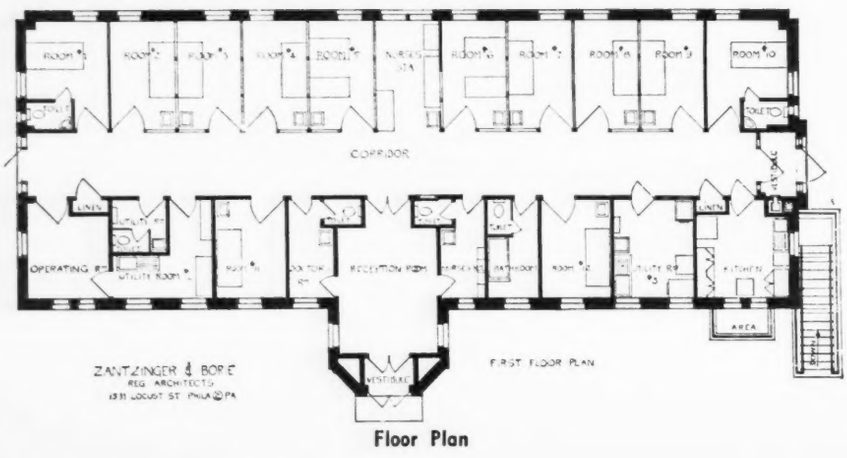
A small operating room provided in the unit will be used only on relatively rare occasions, and it can be readily adapted for the delivery of maternity cases when the occasion arises.

The department's normal capacity is fifteen beds, with the possibility of some expansion during severe epidemics.

Complete equipment is provided for the care of acute poliomyelitis cases, including an iron lung and three spinners for the preparation of hot packs.

Through the energetic understanding of the commissioners of Delaware County, there was provided, within less than two years after the enabling legislation was enacted, adequate protection for the residents of the county from the one type of disease most often overlooked by general hospitals.

Left: Typical cubicle in isolation unit, constructed of metal and glass partitions from floor to ceiling. Below: Floor plan shows layout of 15 bed section with operating room, utility rooms and nurses' stations.



Floor Plan

Courtesy lays the groundwork for

A SUCCESSFUL COLLECTION POLICY

CHARLES S. BILLINGS

Executive Secretary, Kansas Hospital Association, Topeka, Kan.

WHILE the primary purpose of every voluntary hospital is to care for the sick (without charge if necessary), few hospitals, if any, have the resources to provide free service to patients indiscriminately without fear of jeopardizing their financial position.

The board of trustees is responsible for the establishment and development of a sound financial policy, and an important part of this policy is that of credits and collections.

A patient should not be refused admission because he is unable to pay for his hospitalization, yet the hospital should take all the necessary precautions to see that it is not being imposed upon.

The general aim of the policy should be to collect a payment in advance (unless the patient is known to be thoroughly reliable and able to pay), to collect all accounts possible while the patient is still in the hospital, and to follow up unpaid accounts in a manner as business-like as is commensurate with prevailing practices in the community and in the hospital field in general.

The policy should be firm and well defined but not so strict that it would be a hardship to the patient or arouse his ill will. Necessary exceptions should be made by the admitting officer, or credit manager, with the knowledge and approval of the administrator.

The board of trustees having formulated the policy of granting credit and of collecting accounts, the administrator of the hospital is responsible for the execution of the policy. He can establish the necessary methods and procedures and can assign the task of carrying out the details to other persons in the office. At no time should he lose sight of the fact that it is still his responsibility to see that everything possible is done for the patient and that this has a definite influence on the ultimate success of the collection of the account.

It must be realized that not just any person on the hospital staff has a personality and the training suitable for representing the institution in the front office. It is vitally important that all contact with the patient or public in matters of credits and collections be made by carefully selected and especially trained personnel.

In a hospital of 100 beds or less, one individual may perform the functions of admitting officer and credit and collection manager. This person should be selected by, and be responsible to, the administrator. Such a person, usually a young woman, should have as a minimum a high school and business college education; she should be gracious and tactful and should have a genuine liking for people in order to be convincingly interested in the person to whom she is talking.

Subsequent training and instruction are the further responsibility of the administrator. Printed instructions and frequent conferences, especially at first, would be valuable in making this person qualified to answer all questions with an air of efficiency and complete competency.

SYMPATHY IS VITAL

Naturally, it would be difficult to find a person who might possess all of these qualifications, and such a person would be much in demand, but hospital administrators must realize that they cannot afford not to have a capable person in this position. Sympathy and understanding are a very vital part of the services which the hospital extends to the community and cannot be limited to the care and attention the patient receives while confined to his bed.

Many hospitals have adopted a policy of requiring all patients, with the possible exception of those known to the hospital, to pay one week's board and room at the time of admission or within twenty-four hours after entry. This exception is determined and recorded by the admitting officer at time of admission. The principle of charging a week's board in advance is followed throughout the patient's stay. This practice, when successfully administered, tends to reduce losses arising by reason of failure to collect balances due from patients.

An individual's first impression of the hospital is often based on the manner in which he is received by the admitting officer. Persons applying for admission to the hospital are ill and often emotionally disturbed so that great care must be exercised in obtaining the necessary credit information. Considerate handling may build good will and, at the same time, lay the groundwork for the subsequent collection of the account. The same consideration should be shown the relatives who usually are as upset as the patient.

Even in some of the larger and better hospitals patients are compelled to stand at the front desk while all the admittance procedure is carried out. A private office should be provided for credit interviews so that a discussion of personal or confidential matters will not prove to be a source of embarrassment to the person being interviewed.

On occasion, it may be found that a patient does not have the financial means to afford the type of accommodations requested. It then becomes the duty of the admitting officer to persuade the person to accept accommodations within his means, and thus prevent subsequent unpleasantness and difficulties arising by reason of inability and failure to pay for the hospitalization.

The work of the admitting officer, or credit manager, will be greatly facilitated if, at the time of admission, patients are informed of the various

charges made for hospital service, as well as of the policy with regard to the payment of hospital bills. This can be accomplished by providing them with a printed pamphlet containing detailed information relative to hospital charges. Information concerning payment of bills, visiting hours, and responsibility for valuables should also be included.

Separate pamphlets may be prepared for the various patient services, *i.e.* private, semiprivate and ward. This material may also be used advantageously when answering mail inquiries regarding hospital charges.

The duties of the admitting officer, or credit manager, may be summarized as follows:

1. Explain hospital charges and collection policies to the person responsible for the payment of the bill.
2. Determine the individual's financial ability to pay the bill.
3. Obtain adequate credit information for establishing a credit rating for future reference.
4. When warranted, recommend rate reductions or arrange for a reduction of charges if authorized to do so.
5. Determine the individual (patient, relative or friend) or agency (Blue Cross, compensation, public liability, city, county, state or federal) responsible for payment of the bill.
6. Make arrangements for installment payments of the account when necessary.
7. Arrange for a responsible party to guarantee payment of patient's account when circumstances warrant this action.

DETERMINING ELIGIBILITY

Only those who are truly deserving should be admitted as free or part-pay patients; all others should be required to pay the established hospital rates. In determining eligibility for free service, consideration should be given to an individual's financial resources, family obligations, earning capacity, probable length of illness, and other factors which would justify the use of funds administered on behalf of the community.

The admitting officer should exercise careful judgment in differentiating between the patient whose ability and inclination to pay are known and the patient whose credit rating is unknown or is known to be doubtful. There are many good special forms available that can be used in recording detailed financial information for credit and collection purposes. A copy of one of these forms can serve to notify the business

office of the credit arrangements made with the patient.

Rate reductions granted at the time of admission should be subject to the approval of the administrator. It is recommended that he be given a daily listing of all patients admitted under special financial arrangements so that he can keep in close touch with the credit policies of the hospital.

The name of the person or agency responsible for payment of the hospital bill, as well as a summary of the credit arrangements made at the time of admission, should appear on every patient's account. The work of the admitting officer in determining credit ratings will prove to be of relatively little value if the accounting office fails to render bills promptly and in accordance with the terms agreed upon at the time of admission.

Statistics show 9.8 days to be the average length of stay of a patient in a nonprofit general hospital, but when a patient is admitted there is no way of determining exactly how long he will remain in the hospital. When the patient has agreed to pay weekly, and the balance when leaving, the accounting office must assume the responsibility for collections.

Nurses, maids, orderlies and other hospital personnel have been in contact with the patient, and the impression they have made upon him is highly important. It takes more than medical and professional care to make a patient contented while recovering from an illness or injury, and if he has received prompt, kind and courteous care he will be in a more receptive frame of mind when the weekly bill is presented.

After being assured by the nurse supervisor on the floor that the patient may have callers, the qualified person from the business office can cheerfully and tactfully present the itemized bill in a business-like manner, yet with the convenience of the patient in mind. If there happen to be questions about items on the bill, they can be answered right then. This friendly treatment accorded the patient cannot be emphasized too much and will result in good will toward the hospital and will reflect favorably in the final collection of the bill.

Promptness on the part of the accounting department in notifying the credit manager of delinquencies in payment of accounts will often determine the degree of success the hospital will experience in its collections during the patient's stay. When the hospital bill is not paid in accordance with the terms agreed upon, the credit manager should make arrangements to interview the person responsible for the payment of the bill.

Whenever possible, patients should be discharged during regular business hours in order that the patient's account can be given proper attention by the business office. The success in collecting the remainder of the bill at this time is often a matter of timing and of cooperation with the nursing department. The patient should be consulted; if he wants to call at the office or if he is leaving by the ambulance entrance or if he wants the bill brought to his room, his request should be granted if at all possible. The representative from the office should be prepared to accept payment in full or to discuss methods of settlement if the patient is not prepared to pay in full.

SEND CORRECTED STATEMENT

If small charges amounting to not more than $2 or so have reached the office after the final bill has been paid, and the patient has been discharged in the usual manner, he should not be billed for them. If the final bill is unpaid, a corrected statement, with an explanation of the additional charges, should be mailed at once.

There are times when the patient is released by his physician unexpectedly, and the regular routine cannot be observed, but these times are in the minority in a well organized hospital.

In the event the patient is not able to pay the full amount of the hospital bill at the time of discharge, definite arrangements for subsequent payment of the account should be made by the credit manager. These interviews may involve a discussion of personal matters and should be conducted in a private office.

While it is not common practice, some hospitals require the patient to sign a promissory note for the balance owing at time of discharge unless his paying habits are known to be good. This is of especial value if the credit department has obtained additional information that would make this seem advisable. There will be a greater probability of prompt payment of the note if the terms are made with an under-

standing of the patient's income and when he receives it, as well as of his financial obligations and when they must be met.

This note can expedite the collection of the account, especially if there is a tendency on the part of the debtor to dispute the bill. Also, the debtor may be inclined to consider the note a more solemn obligation than he does an open account. Then, too, if legal action becomes necessary, the note is proof of services rendered the patient. Care should be exercised in this matter, for the good will of the patient is of especial importance right at this point.

There are times when a patient leaves the hospital without making arrangements for the payment of the bill. In such instances, it is important that a statement be mailed not later than the following day. If a prompt response is not received, then the regular collection procedure should be followed.

The collection procedures followed after the patient has left the hospital will usually be determined by the financial arrangements made at the time he leaves. In many instances the success of the collection efforts will be dependent upon the effectiveness of the tickler file used to remind the person in charge of collections that certain accounts require attention.

TICKLER FILE EFFECTIVE

A simple yet effective tickler or follow-up system is a double set of thirty-one letter sized file folders. Every time a statement is mailed, a letter is written, a telephone call is made, a promise is made by the debtor, or there is other activity on the account, a copy of the statement or letter or memorandum is placed in the file to come up on the date desired. As this daily folder is removed, attention is automatically called to the specific activity and the necessary action is taken and then set up for the future date. Naturally, the manner of actual follow-up must be in keeping with the terms of payment and will be influenced by the response from the debtor.

Collection follow-up may be managed through correspondence, telephone calls, telegrams and by personal calls.

When a note has been accepted, it is advisable to send a reminder a week before the note, or payment on the note, becomes due. In case the payment is not made a letter should be sent promptly, requesting the reason for the oversight.

A definite policy should be established with regard to the frequency with which collection reminders are mailed. Too frequent notices may create ill will and may result in a refusal to pay. On the other hand, if too long a period of time is permitted to elapse, debtors may be inclined to disregard the notices requesting payment. The response of the debtor will determine, to a great degree, the necessary collection activity on the account.

Careful consideration should be given to the tone and style of the collection letter. It should be friendly, brief and personal, and it should convey the impression that an immediate response is fully anticipated. If the volume of accounts handled makes it impractical to dictate special collection letters to each debtor, form letters may be used, but they should be individually typewritten and signed and so constructed that they will have the personal touch of the writer.

The telephone is perhaps the most neglected channel of communication between the collection department and the debtor. In my experience, it has proved the most effective of all methods in obtaining favorable results not only in the payment of the bill but also in retaining the good will of the debtor. But careful selection and training of personnel are required, and experience is an important part of this training. It is not so much what is said, but how it is said that brings the desired results. Again, friendliness is the keynote of the successful telephone conversation, for only in that manner can the collection department effectively impart the idea that the hospital wants not only the balance due but also the good will of the debtor.

A telegram often proves to be an efficient collection device since it has in it an element of surprise. This element of surprise is perhaps more effective than the actual message it contains. It is useful in issuing an ultimatum, although considerable discretion should be employed in using this means of dealing with delinquent debtors.

Personal contact has the advantage of providing a better opportunity of judging a debtor's circumstances and responsibilities. Some hospitals employ a collector, part time, to call on former patients who cannot be reached by telephone and whose accounts are of some consequence. Some hospitals send a qualified person from the credit department on outside collections. Seldom does a hospital of 100 beds or less have a volume of accounts that would warrant the employment of a full-time collector.

The size of the unpaid balance, the attitude and response of the debtor, and the period of delinquency would be the factors which should determine the necessary collection effort. Some hospitals do little more than send a statement or two on an unpaid balance of $5 or less.

MAY HAVE REAL DIFFICULTY

Even though considerable effort may have been expended in the collection of an account, it is well to assume that the debtor may have experienced real difficulty in meeting the obligation incurred by reason of personal or family illness. It would be good public relations if an expression of appreciation for the debtor's cooperation was to accompany the receipt sent in acknowledgment of the final payment.

As a last resort, when all other collection methods have failed, and after the debtor has been properly notified, the account should be turned over to an attorney or a collection agency. Before an attorney or outside collector is selected, his methods should be thoroughly investigated. The good will of the debtor is valuable and, if at all possible, the methods of collection should not destroy that good will.

If accounts are going to be turned over to an outside collector, that should be done while there is yet a possibility of collection. Collection data reveal that an account six months past due usually yields 50 per cent or less, and the greater the delinquency the less probability there is of collection.

It is regrettable that some hospitals subscribe to the salvage practice. Periodically and indiscriminately, accounts of several years' delinquency are turned over to a collection agency, whose methods are not admired, whose chief aim is its own financial gain, and whose only recommendation is that it does collect the money. The financial returns to the hospital certainly cannot be commensurate to the loss of good will in the community when such practices are followed.

ONE MEDICAL CENTER COMING UP

HARRY HEWES

Federal Security Agency, Washington, D.C.

GOV. J. STROM THURMOND last December 15 affixed his signature to an act appropriating $3,100,000 for the construction and equipment of a 350-bed teaching hospital at the Medical College of South Carolina and therewith made the latest and most important move in a plan that will set up in Charleston one of the great medical centers of the South.

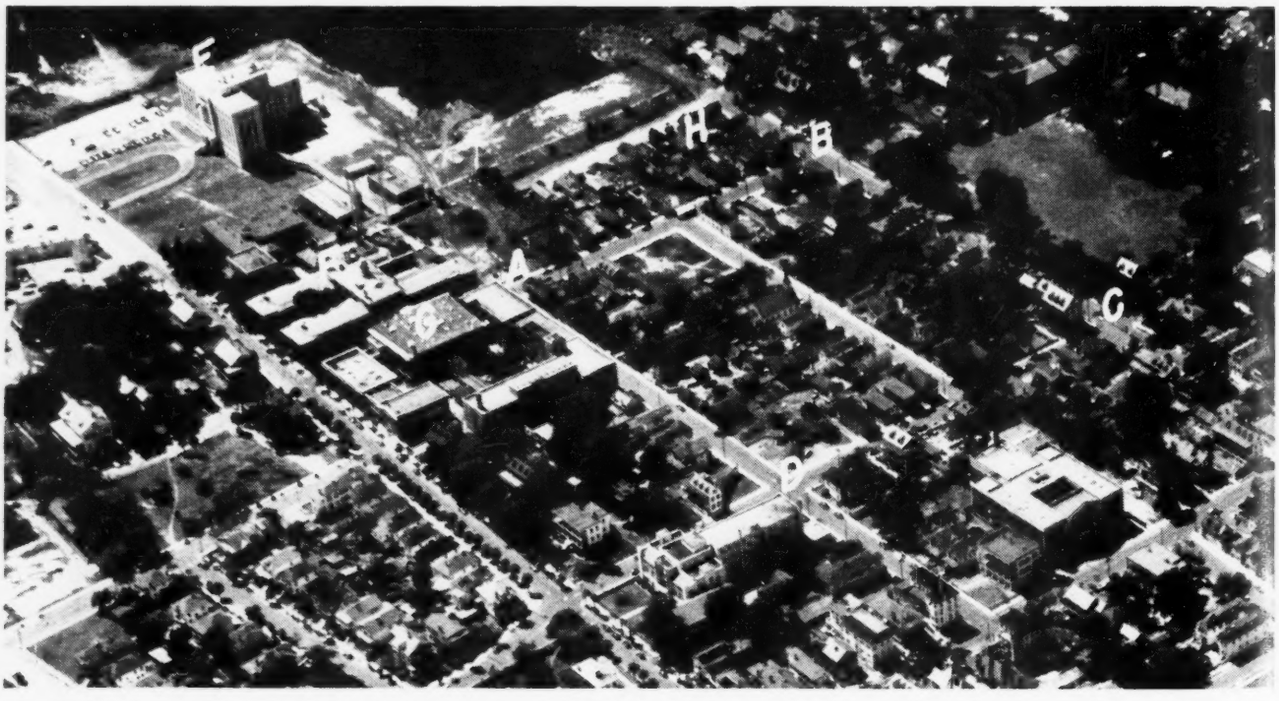
The teaching hospital was one of several projects in a bill which contemplates and authorizes a statewide public health system with the base hospital in Charleston, regional and community hospitals at strategic locations, and a modern well equipped health center in each of South Carolina's forty-six counties, with satellite clinics.

Appropriations in the bill cover hospital facilities to cost the state an estimated $4,050,000, with an additional $1,770,000 in grants for building and equipping the county health centers. These projects are in line with needs set forth in the health facilities survey presented to the State Research, Planning and Development Board which anticipates participation in the Federal Hospital Construction Program as authorized by the 79th Congress.

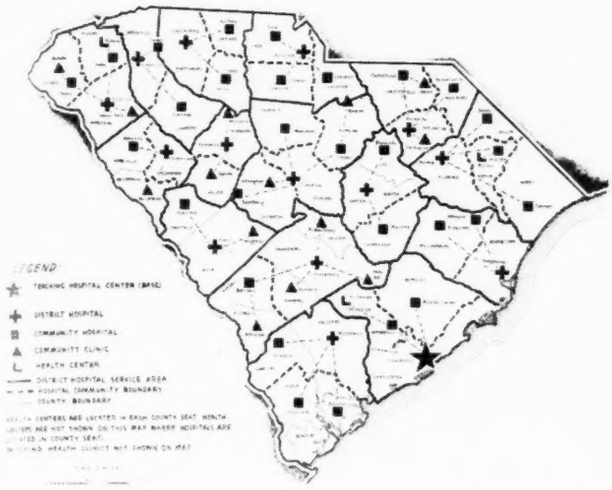
A method was established for estimating the general hospital requirements for a ten-year period based on population trends, purchasing power, and vital statistics. It was estimated that 8145 hospital beds will be required in 1957. Of the 4484 general hospital beds now listed, the survey approved 4119 as acceptable for the purposes of the state hospital plan. The report, however, is much more than a tabulation of existing patient bed facilities and outpatient services. It also considers the grave need for more physicians and nurses. Without a hospital, the well trained and professionally ambitious young doctor cannot practice the kind of medicine he has learned or afford to his patients the benefits of many of the technics of modern medicine.

The new institution is to be a base hospital with all of the equipment, appurtenances and personnel that such an institution requires. It will take patients from every section of the state, and today, so far as the college is concerned, it needs at least twice the number of hospital beds presently available for clinical instruction. The ninety-eight year old association with Roper Hospital is expected to continue.

The Medical College of South Caro-



Aerial view of the Medical Center area in Charleston. A, B, C, D, site of the proposed teaching hospital. E, the new Roper Hospital. F, Roper Hospital, Plant No. 2. G, Medical College of South Carolina. H, site of the proposed county health center. Carolina Skyways photograph.



Above, left: An integrated hospital plan for South Carolina developed in the Health Facilities Survey. Right: The new Roper Hospital — Number 3 in the historic line — built with F.W.A. funds.

lina stands directly across the street from Roper Hospital No. 2, a building erected in 1906, which at that time was one of the finest institutions of the kind in the South. Two minutes' walk through a covered passageway leads to Roper Hospital No. 3, opened for patients in 1946, a seven-story structure built as a war public works project. There are eight other buildings comprising the Roper Hospital plant.

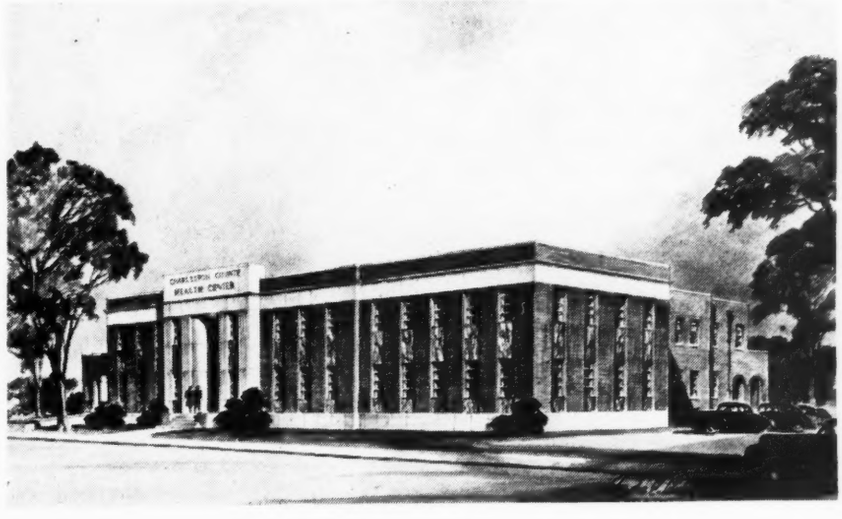
St. Xavier Infirmary, which was enlarged from a fifty-bed to a 120-bed institution during the war, also with F.W.A. assistance, stands a block from the college in the other direction.

The proposed Charleston County Health Center, which will cost an estimated $230,000 and will bring its scattered health offices under a single roof, will be an important unit in the new Medical Center. It has been brought through the blueprint and site acquisition stages, and construction will start when materials and labor are available. All of its facilities for instruction in public health methods and preventive medicine will be open to the students at the Medical College.

About in the middle of this area occupying two city blocks adjoining the college, the ten-story Teaching Hospital will rise, surrounded by these other public health facilities.

The new College Hospital will be of steel and concrete construction with brick facing and stone trim. It will contain not only full facilities for modern medical care but space and equipment fitting to its use as a medical school teaching unit, including teaching conference rooms and laboratories. Operating and delivery rooms will be carefully organized and related to other special facilities, such as a complete radiol-

Above: Perspective drawing of the proposed 350-bed college teaching hospital. Hopkins and Baker, Florence, S.C., are the architects. Below: Architect's drawing of the proposed Charleston County Health Center. Architect is Augustus E. Constantine.



ogy department. Physical medicine, cancer, psychiatry and heart diseases will receive special attention in relation to their increasing importance in research and teaching.

Probably one-third of the capacity will be used for private rooms. Other patient areas will be two-bed and four-bed rooms or small wards. Kitchen, dining room, laundry and heating facilities are planned to afford every possible integration and economy of operation.

The upper floors will be arranged for nurses' and residents' accommodations so that if the predicted demand materializes these floors can be used for patients, and staff houses will be built, at much less cost than hospital construction.

Hopkins and Baker, architects of Florence, S.C., have kept the mood and feeling of Georgian architecture despite the height and other proportions of the building. W. R. Gill is associated with them, and outside special hospital architects and experts on hospital organization and operation have been engaged for consulting service.

The Medical College of South Carolina, like other medical schools throughout the country, is confronted with a demand for increased facilities for students, among them many veterans entitled to assistance under the G.I. Bill of Rights. The increased enrollment now accepted and contemplated, however, does not constitute simply a post-war flurry, and there will be continued demand, as there was before the war, for enrollment even beyond contemplated capacity.

Not only will the new hospital give opportunity for the training of more than double the number of interns, residents, nurses and technical students that can now be accommodated, but plans are now being formulated for relating the Medical Center with other hospitals and health centers in the state system, so that additional approved training services can be developed and sponsored, thus leading to a spread of the teaching opportunity throughout the state and promising permanent location to more physicians in needy areas.

NATIONAL ASSEMBLY OUTLINES HEALTH AND HOSPITAL NEEDS

WITH nearly 800 delegates representing public and private health agencies of all kinds and shades, the National Health Assembly called by Federal Security Administrator Oscar Ewing at President Truman's request deliberated for four days in Washington last month about the state of the nation's health and what can be done about it. The diagnosis: Not so good as it might be, but not so bad as a lot of people think. Recommended treatment: Everything short of compulsory health insurance.

A week after the assembly closed, an enthusiastic government release crowed that Administrator Ewing was "still receiving congratulatory messages" on the success of the assembly and was "deluged with requests" for reports of its fourteen separate sections (devoted to such subjects as medical care, hospitals, nutrition, research, maternal and child health, chronic disease). An editorial in the *Journal of the American Medical Association* said the assembly "established what is apparently a new record for such conferences" and "resolved the doubts and anxieties" of those who suspected it might be aimed at propagandizing in favor of the administration's national health program. As a result of the conference, the *Journal* declared, "the nation seemed to be on the way toward the development of a plan for the production and distribution of medical services suitable to the American democracy."

One floor removed from the *Journal* office, A.M.A. Secretary George F. Lull was less impressed. "The assembly seems to have caused about as much noise, nationally, as a ray of moonlight falling on a cup of custard. The $45,000 show . . . accomplished among other things a lot of talk," Dr. Lull said.

For hospital people, the talk was charged with interest. The Hospital Facilities Section of the assembly recommended continuation and extension of the federal hospital construction program under a more flexible plan which would be more adaptable to changing community needs. The following paragraphs are condensed from a statement released by the Hospital Facilities Section:

The problem of extending medical care and the services of the modern hospital into rural areas is one which requires careful planning and coordination of effort on the part of all concerned—the professions and the general public. Public health services, health centers, community clinics, small hospitals—all properly correlated and integrated with the services of larger hospitals and their specialized personnel—appear to offer the best solution of the problem.

Revised conclusions and recommendations of the section, representing summaries of all the sessions, were adopted as follows:

In summary, this report attempts to review briefly the development of the hospital in this country, to outline its present place and status, and to help chart its course for the future.

Full recognition is given to the vast strides made by the American hospital in attaining its present vital and strategic place among the nation's health resources. Yet, much remains to be accomplished in achieving the ultimate aim of adequate hospital services for all the people without regard to race, creed,

color or economic circumstance. In order that maximum progress may be realized toward this goal in the next ten years, it is recommended that:

1. The program under the Hospital Survey and Construction Act should be continued and extended under a policy of flexibility permitting adaptation as may be required to meet changing needs. The present authorization of $75,000,000 per year should be increased in view of the urgent needs for the establishment of hospitals, additional hospital beds, and clinics and health centers in many areas of the country.

2. The program under Public Law 725 and the hospital program of the Veterans Administration should be closely integrated in the interest of good planning.

3. Hospitals within service areas should be functionally or organically associated with one another so that the patient may benefit from the resources of all.

4. The full cost of hospital services for patients for whom governmental agencies have assumed responsibilities should be paid from tax funds. The same principle should be observed by nongovernmental agencies purchasing hospital care.

5. Hospitals and health departments and all other health agencies should seek every method for coordinating their efforts and integrating their functions in the interests of greater efficiency and service.

6. Diagnostic clinics, outpatient services and home medical care, and allied programs should be developed more extensively in extending health services for all.

7. Hospitals should intensify and extend their basic activities in research and education.

8. Preventive medical and dental service and public health education should be carried out more widely as regular functions of the modern hospital.

9. Insofar as possible, the general hospital should provide facilities for the care of all types of illness, with increased attention to the care of the patient with long-term illness.

10. The pressing need for additional facilities for the care of the mentally ill and chronic diseases in general hospitals makes it necessary that special emphasis be given to this problem in the original state hospital plans and any revision of these plans under Public Law 725. Careful study to develop recommended standards is needed in this area for the guidance of state agencies under this act.

11. All hospitals, nursing homes, and other facilities for the care of the sick should meet at least minimum standards through the mechanism of licensure in order to develop and adequately to meet good standards of patient care.

12. The control of local facilities should be by the people in that locality on a cooperative or a community basis when possible, with an elected board of directors representative of lay and professional groups.

13. Lay and professional organizations and governmental agencies should join in conducting a health education program and in developing plans for adequate facilities and health services which will include well coordinated and highly integrated networks, mobile units, clinics, community hospitals, regional hospitals, and great medical centers.

It is desirable that funds, public or private, be available to facilitate the exchange of personnel needed for high quality service in an integrated hospital system, the Hospital Facilities Section felt. General hospitals should be stimulated to provide facilities and personnel for the diagnosis of mental diseases and for the treatment of those patients who are not in need of long-term institutional care. Mental hygiene clinics should be established in the outpatient departments of general hospitals wherever competent professional service is available. Due attention should be given to the need for expansion of the services of special hospitals for nervous and mental diseases.

Hospitals and outpatient departments should concern themselves with the support and maintenance of worthwhile programs of disease prevention.

MUST REPRESENT THE PUBLIC

The boards of management of voluntary hospitals should be composed of members who are broadly representative of the public. Definite liaison arrangements should be made among the managing board, the administrator, and the medical staff for the discussion of professional affairs and the establishment of administrative and professional relationships.

Care of the ambulatory patient in the outpatient department should be extended as a means of preventing hospitalization and to provide service to the general public as well as for patients before or after their stay in the hospital.

Negroes should have the same high quality of professional and institutional care as is available to all other segments of the population. There should also be increased opportunity for education and training for personnel to serve minority groups.

Dr. Charles F. Wilinsky, Beth Israel Hospital, Boston, was chairman of the Hospital Facilities Section of the assembly. Among the section members were Dr. Arthur C. Bachmeyer, University of Chicago; George Bugbee and Graham L. Davis, American Hospital Association; Dr. Paul A. Davis of Ohio, president of the American Academy of General Practice; James A. Hamilton, University of Minnesota; Dr. Henrietta Herbolsheimer, Illinois Health Department; Fred Hovey, American Surgical Trade Association; M. R. Kneifl, Rev. John W. Barrett and Rev. Donald A. McGowan, Catholic Hospital Association; H. J. Mohler, Missouri Hospital Association; Oliver G. Pratt, Hospital Association of Rhode Island, and E. A. van Steenwyk, Richard Jones and L. C. Wells, Blue Cross Commission.

Hope Springs

TYPESETTERS and compositors in our Chicago printshop have been away from their work for twelve weeks as this is written, a circumstance which has occasioned some changes in the appearance of our magazine and, necessarily, many delays in our publication schedules. The understanding attitude of our subscribers and advertisers during this emergency period has been greatly appreciated. It is hoped that normal operations may be resumed in the near future —resulting in a bigger and better, and prompter, MODERN HOSPITAL.—The Editors.

A GUIDEBOOK GETS THEM OFF TO A GOOD START

NELSON O. LINDLEY
Administrative Intern
Beth Israel Hospital
Boston

TODAY'S hospital employe approaches his new job with a mixed attitude of apprehension and questioning. To many workers the world of the modern hospital is quite novel and difficult to understand. Every institution can give its new workers a good start if a guidebook is so written that it will explain some of the basic principles of hospital organization and management.

The booklet need not be long or go into great detail, but it does call for a careful consideration as to what are the minimum requirements for effectiveness. There are definite limitations as to the amount of material that can be inciuded, as well as the amount that would be read and understood by the employes.

Often it has been found easier to slur over the organization and departments of the hospital and make the guidebook into little more than a list of local rules, regulations and policies. This may be the easiest thing to do, but it does not answer the questions that arise, or help the employe to understand his position in the hospital. It might be better to have a separate section for rules and regulations—or better yet a separate booklet. After all, an employe guidebook achieves its purpose only if it is read and understood.

In general, it can be said that a hospital is quite different from an industrial organization. It is the job of the guidebook author to interpret these differences clearly and simply and to give the employe an accurate, complete picture of the hospital.

The biggest problem facing the author of such a booklet is to anticipate the commonest questions of new employes and to decide how they can best be answered. To be effective a guidebook must answer these five basic questions:

1. What kind of place is a hospital?

The answer to this must be kept on a simplified level and at the same time should explain clearly such terms as "voluntary," "nonprofit," "charitable" and other words so important for the proper understanding of the hospital system. An additional way of showing the employe what makes a hospital run is to explain exactly what are the lines of authority and responsibility in the organization. Added to this organizational diagram should be a brief explanation of the duties and functions of top hospital officials.

2. Who owns the hospital?

Unfortunately, voluntary hospital finances are often misunderstood by new employes, and a real effort should be made to explain the nonprofit character of the organization, the charity work done, and the sources of hospital income. A concise popularized financial statement would go far toward answering this question.

3. What do I get besides my pay check?

Money alone is not always the determining factor in accepting a new job, and the answer to this question gives the hospital an opportunity for a little self-advertising. This section of the guidebook could list and describe the benefits, vacations, pensions, Blue Cross coverage, and sick leave offered by the institution.

4. Is my job secure?

The question of job security ranks high in the minds of all new employes. The answer to the question is one of the hospital's strongest selling points. The relatively stable nature of hospital work as compared with industry should be emphasized and clearly pointed out. The amount of seasonal fluctuation is slight, and hospitals should be quick to use this point in their favor.

5. Will my talents and loyalty be recognized?

No employe will stay on the job long if he feels it is a dead end. The problem, then, is to review briefly personnel practices and policies so that the newcomer will be convinced, first, that there is a definite plan for advancement, and, second, that he will be given a fair chance to improve his position. This is a good opportunity for the institution to show off its system of job analysis and rating, periodic wage advances, grievance procedure, suggestion system, and departmental meetings. An effort must be made to assure the employe that he is important as an individual and will not be lost in the organization.

If the author of the hospital employe guidebook can answer these five questions thoroughly and clearly, he will have done a great deal to interpret the hospital for the new employe. The way of answering these questions is something else again. The average reader has no experience or knowledge in the hospital field, and the language and manner of presentation must be geared to this situation. There is no advantage in using large impressive words in this publication. The employes will only be confused. It is natural to write up all the strong points of the institution in some detail. However, if this does not give a complete picture of the hospital, it will never be considered a really good guidebook. The newcomer will find out all about the hospital sooner or later—both the good points and the bad. It is best to be honest and frank at the beginning rather than to use the guidebook solely to promote the hospital.

The whole problem of progressive personnel relations has become one of great interest and importance to hospitals, and they are looking to industry as their guide. The most effective industrial employe guidebooks almost invariably attempt to make the employe feel he is an important part of the company "family." This ability to interest the newcomer as an individual within a

larger group is just as important in hospital booklets. In fact, hospitals have a much stronger position to exploit because they are dealing with human lives and not just units of production. A genuine feeling of welcome and personal interest does a great deal to impress the new employe that the hospital really is a pretty good place to work.

Some hospitals began publishing employe booklets many years ago. Although they may have been accurate and complete at the time of publication, there is a tendency to forget the necessity for constant revision. Once a hospital has made the decision to have an employe guidebook, it has taken on the added responsibility of keeping it up to date. The booklet loses its effectiveness completely if it no longer represents a true picture of the hospital.

EVERYBODY LOVES A PICNIC

DONALD M. ROSENBERGER

Director
Hamot Hospital
Erie, Pa.

A CHRISTMAS party during the holidays of 1946 was thoroughly enjoyed by a number of the employes of Hamot Hospital, Erie, Pa., but, hospitals being what they are and the party having been held in the evening, there were many people whose duties kept them from attending the celebration.

However, it was this Christmas party that touched off one of the most successful Hamot Hospital employe gatherings on record. Several hospital workers, talking over the holiday party, remarked on how much fun they had and regretted that everyone could not attend.

During these conversations was born the idea of a summer outing, which would be somewhat of a "round the clock" affair, so that all the employes and their immediate families could attend. The idea grew as the year progressed, and last July 24 the first big picnic for Hamot Hospital employes and their families was held.

Planning such an outing was a big job, especially planning it so that not only those who were on the odd shifts could be there but those persons who are on call at all times could enjoy the outing, safe in the knowledge that in an emergency they could reach the hospital in minimum time.

Upon hearing about the desire for such a gathering, the management turned the problem right back to the employes, who would have to become enthusiastic over the project to ensure its success.

Before long, the employes had selected a chairman, J. E. Seyboldt, the purchasing agent, who at some time during the year has contact with practically everyone in the institution. Mr. Seyboldt immediately began to surround himself with enthusiastic committee members from all over the institution.

Professional employes mixed with nonprofessional personnel on the committee—staff nurses, employes from laundry, kitchen, housekeeping staff and laboratory—and plans for the affair were under way a good two months before the date set.

Water Works Park on Erie's historic peninsula was selected as the picnic site. From the hospital it can be reached by boat or by car within fifteen or twenty minutes. The park, owned by the city, is on a state reservation; it provides all conveniences for picnics and prohibits alcoholic beverages.

Next on the list in the planning were the hours—and they had to be hours that would be convenient for everyone associated with the hospital. This problem was solved by planning for the picnic to start at 10 a.m. and to be ended at dark when park regulations require all picnickers to leave.

Then came food and equipment. The committee did an excellent job in apportioning the noon and dinner meals, with everyone supplying a share of the sandwiches and the other foods for himself and his family, and the hospital providing the ice cream, cake and coffee. Excellent planning in advance determined how many would be on hand for the noon meal and how many for the evening meal, and, of course, those who could be there for both were welcomed and well provided for.

Finally came the program of entertainment. This is always important at a big outdoor gathering so that time will not hang heavy on anyone's hands. Two girls on the staff, Dorothy Bemer and Gloria Santomenna, were charged with this part of the arrangements.

The results of the outing speak for the efficiency with which all committee members worked, and also for the enthusiasm of the entire hospital personnel. At one time, more than 300 persons were being served a picnic meal, and the entire affair, from the starting time at 10 a.m. until dark, was a constant pleasure.

Swimming, horseshoes, softball and other games for adults were in progress continuously. There was a full program throughout the day for the youngsters that kept them busy and entertained all day and sent them home at night ready for sleep and thoroughly happy. One candid camera enthusiast took more than fifty snapshots of those at the picnic in all sorts of poses and situations.

All of those on the employe list whose services might be needed throughout the day and evening went to the picnic with easy minds after hearing of the arrangements made to get them back on their jobs in the shortest possible time if their aid was needed. A special telephone wire was kept open from the hospital to the caretaker's lodge at the picnic grounds, so that when someone was wanted in a hurry he was able to be back at the hospital within the time it took to step into a fast boat and skim across the 2 miles of bay or enter a car and make a fast drive over the park road.

The picnic was the subject of conversation during ensuing days at the hospital not only because of the fun they had but also because of the desire for an annual observance.

SCHOOL FOR ATTENDANTS

Supplies the demand for bedside nursing

FRANCIS J. BEAN, M.D.

Former Administrator, Putnam Memorial Hospital, Bennington, Vt.

WELL over a year ago, it became apparent that the number of nurses available for regular duty in hospitals was far less than the supply and that, furthermore, attempts to interest girls in entering the nursing profession were being met with only moderate success. The situation is only slightly improved today, and leaders in the nursing and hospital world are still wrestling with the problem of how to supply nursing care and give adequate nurse training to meet America's needs.

QUESTION NURSING CURRICULUM

It is but natural under the circumstances that serious questions arise as to the content of the nursing curriculum, the minimum training required to produce a good bedside nurse, and the wisdom of previous nursing faculties. Will a lesser trained individual serve? How many grades or types of nurses should we have? Let us make some sense out of our education of nurses and adapt it to present day demands.

In view of such a situation, and because they were familiar with the hastily trained cadet nurse, and also with the number of small hospitals in Vermont that were doing their best but had not the facilities to conduct a really top-grade school for registered nurses, the authorities at the Putnam Memorial Hospital, Bennington, Vt., determined to establish a school for attendant nurses. This was done with several objectives:

1. To provide additional bedside nursing service as soon as possible.
2. To furnish the community with the type of nurse it seemed to want both in and out of the hospital.
3. To help develop a new pattern of nursing education.
4. To infuse an educational atmosphere into an institution which lacked it.

After considerable preliminary study, a curriculum was drawn up, entrance requirements were outlined, facilities were established, and a bid for students was made in June 1947 with little but well advised publicity. Sufficient applications were received to permit a careful selection of students. The school was opened in September with ten students, all that it was felt desirable to accept for a beginning class.

As the project enters upon its ninth month of operation, it would appear that the initial difficulties have been overcome, that there is a rapidly developing recognition of the place of the attendant nurse, and that the students themselves are more than happy with their choice of profession. Largely because of limited dormitory space, a class was not admitted this February, but one is already forming for September, and it is anticipated that two classes a year will eventually be desirable.

The requirements for admission to the school are simple but definite: age, 18 to 45; preliminary education, at least one year of high school. A personal interview is also required. A student must be an American citizen, in good physical and mental health. She must pass a physical examination, including dental and eye observation, and is given the usual immunizations. It has been interesting to note that the majority of applicants so far have had more than the minimum requirements of educational standards.

The course of training lasts fifteen months, there being a preliminary probationary period of six weeks. Affiliation for the students, early in the course, has been arranged with the Household Nursing Association in Boston, where the students go for specific training in cooking and housekeeping duties.

The clinical experience in the hospital has been divided into the following: (1) medical service, male and female; (2) surgical service, male and female; (3) mother and new-born child, including formula room; (4) care of the child.

385 HOURS OF CLASSWORK

Approximately 385 hours of didactic work are included in the fifteen months' course. This consists of classes and demonstrations in the following subjects:

Ethics.
Elementary anatomy and physiology.
Hygiene: personal, mental and social.
Elementary bacteriology.
Common drugs and their administration.
Nursing care of the patient.
First aid.
Home nursing.
Nutrition and cooking.
Home housekeeping.
Care of mother and infant.
Care of the child.
Important signs and symptoms.
Diseases that can be adequately cared for by the attendant nurse.

Some of the nursing duties that the attendant nurses are capable of doing are the following:

Cleaning hospital units and making unoccupied beds.
Care of flowers.
Care of linen and laundry.
Care of equipment.
Care of utility rooms.
Making occupied beds.
Bed bath.
P.m. and a.m. care.
Care of hair; shampoo in bed.

feeding patient.

Hygiene of skin, teeth, nails; care of dentures; care of bed sores; care of mouth.

Giving and removing bedpan and urinal; measuring urinary output.

Care of incontinent patient.

Care of body after death.

Temperature, pulse and respiration.

Assisting with physical examinations.

Collecting, observing and recording of specimens: sputum, urine, stool and vomitus.

Admission of patient.

Transfer and discharge of patient.

Anesthesia bed.

Hot and cold applications.

Serving hot water bottles, poultices, stupes.

Hot, wet and dry compresses.

Arm and foot soaks.

Ice caps and collars.

Alcohol sponge.

Gargles and throat irrigations.

Nose drops.

Steam inhalations and croup tent.

Care of artificial eyes.

To this list will be added the administration of common drugs, enemas and douches, and perineal care.

The hospital furnishes uniforms and books and has adopted an individual gold and white uniform, including a cap. The cap is presented after the preliminary period. Formal capping ceremonies were held on January 27 for the present class of students.

During the first six weeks, or probationary period, the students receive no remuneration, but thereafter a small stipend is paid monthly. Allowances are made for vacations and sick leave. The students work an eight-hour day, including their care of patients.

STUDENTS NOW WORKING

At the present time, the students are actively working in the wards and private rooms of the hospital and have been most helpful. Duties are specifically stated so that there is little confusion between that which the registered nurse does and that which the attendant nurse does. A great deal of time and effort is being given these women to teach them to be good bedside nurses to the not too critically ill patients, leaving technical duties and critically ill patients to the graduate nurses.

It may be interesting to know that since the school started a large number of inquiries has been received, which indicates real interest in training of this type of individual in this area. The school is, at present, one of two operating in Vermont, and although the state has now no law which provides licensure of such individuals, it has been considered in previous legislatures, and a new bill incorporating the best features of similar laws in other states will be presented before the next session of the legislature.

Legal titles given to individuals in this kind of nursing vary and include licensed attendant, licensed attendant nurse, trained attendant, practical nurse, nurse's aide, nursing assistant, and vocational nurse. In view of the difference of opinion as to terminology it seems at the moment a matter of individual preference. We are at present using the term attendant nurse.

The hospital is approved by the American College of Surgeons and by the American Medical Association; it is a member in good standing of the American Hospital Association and has adequate registered nurse supervision with full-time qualified instruction for the student attendant nurses. It is striving to establish a school that will be second to none in its standards and is convinced that its graduates will be able to fill a place with credit to themselves and to the nursing profession.

No descriptive pamphlet of the school has yet been published, although any inquiries about it may be directed to the director of the school or the administrator of the hospital.

HAZARDS OF FOLIC ACID

Folic acid has recently been reported widely as a specific in the treatment of certain anemias, particularly of pernicious anemia. O. C. Hansen-Pruss, M.D., associate professor of medicine, Duke University Medical School, in an article entitled "Relapse of Patients With Pernicious Anemia Receiving Folic Acid," in the November 1947 issue of the *American Journal of the Medical Sciences,* points out that when a well recommended remedy enters the therapeutic field a tendency soon develops to look upon it as an unfailing curative agent, especially when the drug is described as a specific.

As a result, many practitioners and a host of misinformed laymen believe today that folic acid is at least unfailing in the treatment of pernicious anemia. This misconception can lead to drastic consequences, as Dr. Hansen-Pruss points out in reviewing the case histories of two patients who had relapses while receiving folic acid.

The first patient, a 31 year old male, in 1941 first developed a clear cut picture of pernicious anemia which responded well to liver extract therapy. In 1946 he suffered a relapse after discontinuing liver therapy three years previously. He responded well to folic acid therapy for five months and then had a second relapse despite increased doses of the drug. When liver extract was reinstituted, the relapse was overcome.

The second case was a 63 year old male with a more advanced pernicious anemia, who had never had therapy and who responded well initially to folic acid, although his blood picture never completely approached normal limits even on large doses of the drug. The relapse occurred ninety days after therapy had begun. He then reacted properly to standard dosages of liver extract.

WILL NOT MAINTAIN REMISSION

It becomes apparent, therefore, that in some patients, the accepted dosage of folic acid will not maintain a hematological remission. In thirty other patients with pernicious anemia, using the reticulocyte count as an index of adequate response to the folic acid therapy, it was found adequate in seventeen, fair in ten, and unsatisfactory in three. The author concludes that folic acid by mouth seems to lack some of the properties of purified liver extract administered parenterally.

This report, and others in which the evidence seems to show that folic acid, even though it may reverse the blood picture, may not affect the neurological progression of the disease, suggests that the complete answer to the therapy of pernicious anemia has not been found. The practitioner would do well to proceed cautiously with folic acid therapy. — EUGENE D. ROSENFELD, M.D.

PEOPLE IN PICTURES

In recognition of his services to voluntary hospitals, Roy Larsen (left center) is presented a citation from the Greater New York Hospital Association by Vincent R. Impellittieri, president, Council of the City of New York. Helen Hayes and Murray Sargent, president of the association, are the observers at the ceremony.

Above: Dean Mary A. Maher of the Boston College School of Nursing addressing a New England Hospital Assembly panel. Other participants are: l. to r., Dr. Albert G. Engelbach, president-elect of the assembly; Dr. E. M. Bluestone, Montefiore Hospital, New York City, and Homer Wickenden, secretary of the National Health and Welfare Retirement Association, New York City.

Left: At the Southeastern Assembly of Nurse Anesthetists (left to right) were Dr. Alton J. Ochsner; Evelyn Allen, president of the assembly, and Dr. John Adriani, director, department of anesthesia, Charity Hospital, New Orleans.

Left: Regina Kaplan, new president of the Mid-West Hospital Association, with Past President Lawrence C. Austin and Dr. Malcolm T. MacEachern.

Right: Surgeon General Scheele, U.S. P.H.S., presents a check for the government's share of the construction cost of Suwannee County Hospital, Live Oak, Fla., to Edward Straughan, who presents a check for a like amount to T. T. Scott, chairman of the board of trustees.

Left: Earl C. Lackey presenting "Laughter Is Important" at the Alabama Hospital Association luncheon. At the speakers' table are (l. to r.) President Harry W. Smith; H. F. Singleton; E. B. Cavalori and Rev. Conrad Myrick, St. Andrew's Episcopal Church.

Right: Faculty members at the recent Ontario institute for administrators included: Dr. Harvey Agnew, J. M. Tutt and Dr. Fred W. Routley.

SMALL HOSPITAL FORUM

DOCTORS MAKE THE RULES

and usually keep them

IN MOST small hospitals, the surgical department tends to its own business of making up schedules, posting them and seeing that operating room rules and schedules are carried out. In general, problems developing in connection with operating room procedures are handled by the staff, with only an occasional case involving the administrator or the board of trustees, a survey of small hospitals revealed. The survey covered sixteen hospitals in all parts of the country, ranging in size from twenty-five to 135 beds.

In nine of the sixteen hospitals, the schedule of operations is made up every day by the surgical supervisors. In five hospitals, the schedule is made up instead in the admitting office, and in two cases the administrator's office makes up the schedule. In all cases, of course, the completed schedule is posted in the surgical department. Usually, copies are also kept on hand in the admitting office and the nursing office. Several administrators regularly get copies of the operating schedule, and in a few hospitals copies are also posted in the staff room, laboratory and outpatient department.

In six of the responding hospitals, there is no deadline for scheduling operations (excluding emergencies, of course, which are always unscheduled in the sense of this survey). The other hospitals will schedule an operation at any time up to a specified hour the afternoon or evening before the operation—4 o'clock in several cases; 5, 6 or 7 o'clock in others. Two hospitals will add operations to the schedule up to 8 o'clock in the morning of the same day.

Every hospital in this group requires, in accordance with the procedure demanded by hospital approval authorities, that the surgeon's preoperative diagnosis must be entered on the patient's chart before the operation can go forward. A few hospitals are a little less strict about enforcing other aspects of preoperative record keeping.

One hospital, for example, does not require that the urinalysis report be entered on the chart before operation. Two hospitals will permit the operation without entering the history, and two do not demand that results of the physical examination be written into the chart preoperatively. Reports of laboratory procedures other than urinalysis are mandatory in twelve of the sixteen hospitals, and only three of the group require a record of the complete blood count.

In ten of these hospitals there is no set rule about adhering to the schedule. "Each doctor adjusts himself to others on the schedule," one administrator reports. "If a surgeon is late, and we are unable to locate him by telephone," another comments, "he goes to the end of the schedule and waits." Still another administrator says, "We have no set time limit. An effort is made to work it out on an individual basis. However, if a surgeon's lateness interferes greatly with another case, his operation is canceled and rescheduled later."

In several of the hospitals an attempt is made to keep the schedules tight. In one case, only fifteen minutes' leeway is permitted before the operation is canceled or dropped to the bottom of the list. Two hospitals give the tardy surgeon twenty minutes' grace; two others allow thirty minutes, but one of these acknowledges that the deadline is "not strictly adhered to."

Who cracks down when irregularities occur in the observance of operating room rules? There is no clear cut answer to this question that applies to all the hospitals in the present group. In eight of these hospitals, the surgical supervisor has authority to hold up or to prevent an operation if rules governing scheduling or the patient's chart have not been observed. In about the same number of hospitals, the administrator may also hold up an operation until the rules have been complied with.

In one hospital, only the chief surgeon has this privilege. In another, either the supervisor or the administrator may delay the procedure, but only until the irregularity is referred to the chief of surgery, who may demand that

THANKS TO THESE CORRESPONDENTS

HOSPITAL	RESPONDENT	BEDS
New Milford Hospital Inc., New Milford, Conn.	Muriel M. Russell	26
DeKalb Public Hospital, DeKalb, Ill.	Edith Siedenburg, R.N.	40
Hadley Memorial Hospital, Hays, Kan.	Thelma Wade, R.N.	50
Boone County Hospital, Columbia, Mo.	Bertha Hochuli, R.N.	53
Scripps Memorial Hospital, La Jolla, Calif.	Robert B. Witham	55
Black Hills General Hospital, Rapid City, S.D.	Alice Hays, R.N.	57
Theda Clark Memorial Hospital, Neenah, Wis.	Esther C. Klingman	64
Southside Community Hospital, Farmville, Va.	J. M. Cofer, Jr.	65
Hospital for Crippled Adults, Memphis, Tenn.	S. Truman Lewis	66
Good Samaritan Hospital, Rugby, N.D.	Josephine Stennes	70
Pocatello General Hospital, Pocatello, Ida.	Lloydena Grimes	75
Jewish Hospital, Louisville, Ky.	Glenn M. Reno	85
Miller Memorial Hospital, Duluth, Minn.	Frances Eckman	94
Beebe Hospital, Lewes, Del.	W. W. Ellis	125
Bushwick Hospital, Brooklyn 21, N.Y.	Fred K. Fish	126
Yorkton General Hospital, Yorkton, Saskatchewan	K. Francis	135

the record be completed or permit the operation to go forward anyway, as he sees fit.

When repeated violations involving the same surgeon occur, a fairly routine procedure for enforcement and discipline exists—referring the case to the staff committee, with the administrator or the board of trustees in reserve.

One hospital reports that surgical regulations are enforced through a hospital council arrangement. The same rules prevail in all hospitals in the area, it is explained, and violations are referred to an inter-hospital committee of doctors. The administrator reports that this system is "very effective." Another hospital has a system of small fines for infractions—25 cents for one violation, 50 cents for another, and so on. The money goes into an instrument fund, and the results are described as "good."

Few hospitals, as a matter of fact, report that doctors regularly disregard the hospital rules. In fact, ten of the sixteen hospitals in the group indicate there are so few violations that this is not really a problem at all. Others are not so fortunate; several administrators say the doctors don't observe the regulations too carefully, and efforts at improvement have not been very effective.

"Our system is not satisfactory," one administrator stated frankly. "However, we are working on the problem and hope soon to set up a system with teeth in it."

That this can be done was shown in the observation of another administrator who described the activities of a joint conference committee which included representatives of the medical staff and the board of trustees.

"We have spent every effort toward making the staff realize that it is responsible for self-government and discipline," this administrator related. "Much was accomplished through our joint conference committee, with good board representation on the committee. Repeatedly, the board found it necessary, through its representatives on the committee, to remind the medical members of their responsibility.

"It took repetition, patience and some pressure, but we're over the hump, and cooperation is very effective now," this administrator concludes. "If your strongest members are represented in such a joint committee, the idea will finally take hold."

The prevailing practice in these hospitals is for the anesthetist to accompany the surgical patient back to his room following the operation. The anesthetist makes the trip routinely in nine of the sixteen hospitals. Others who share this function are, in order of the frequency with which they were named in the replies, nurse, surgeon, orderly, nurse's aide, and intern.

Twelve hospitals have an ironclad rule against letting relatives of the patient enter the operating room. Of those that acknowledged that the bars may be dropped on occasion, one said this was done only when the relative was a doctor or nurse; two relax the rule whenever the operating surgeon requests it, and one allows the relative to enter when he insists to the point of getting a lawyer to defend his right to be present.

Methods of cleaning the operating room and of keeping it clean are fairly well standardized, the survey indicated. Following a septic case, thorough scrubbing and cleaning with antiseptic solution is the rule. Surgical instruments are always autoclaved in four hospitals and are sterilized by boiling in two. In the others, either autoclaving or boiling is used, depending upon the instruments and circumstances involved.

Most of the hospitals scrub the operating room every day, regardless of the nature of surgery performed; a few clean on weekly or "as needed" schedules. Walls and ceilings are scrubbed, on the average, three times a year. In ten of the sixteen hospitals, the shoes worn by surgeons and nurses are scrubbed after each day's use.

VOLUNTEER ACTIVITIES

In Michigan Communities

Several slogans indicate the function of the Women's Service League of the Allegan Health Center, Allegan, Mich. "The hospital never says 'No' and neither do we" is the primary motto of this group. Its president, Mrs. William E. Schmitz, asserts that the league is "not a pressure group in hospital management."

The 600 league members enrolled in this predominantly rural community are obtained in a house-to-house canvass conducted each February.

Newly created is the hospital auxiliary at Sturgis, Mich., a strictly 1948 venture. On May 20 the women held their first large tea, not a silver but a folding money tea. Eleven guilds have already been organized, the nursery and flower guilds being the first to function.

The nursery guild is sending out birthday anniversary cards to children born in the hospital. These greeting cards, handsomely lithographed in color, are now being sent to 1 year olds, and these children will continue to get cards each year until their tenth birthday. The hope is that this reminder of the hospital will result not only in good will but in small contributions. Mrs. D. M. Kane is the general chairman of the auxiliary. Olive Jane Brown, superintendent of Sturgis Memorial Hospital, a forty-bed institution, says the nucleus of the new auxiliary was one of the women's clubs.

In South Haven, Mich., is a hospital guild with 400 members serving a forty-two-bed hospital in a town of 5000. The women are kept active in a number of different committee projects: loan closet, library, surgical dressings, desk service, tray decorations, flowers, visiting, serving, social service, transportation and, of course, membership.

The loan closet committee has a storeroom in the hospital basement to keep its large supply of layettes, rubber sheets, combs, shower caps, ice bags, enamel pans, wheel chairs, and the like. No charge is made for any loan to townspeople except for wheel chairs.

Harvest Day Planning

About this time of year the Aid Society of Emerson Hospital, Concord, Mass., begins to plan for its annual Harvest Day held in mid-October. Last year's contributions were bigger than ever before: vegetables, canned goods, and home preserves came in from far and near.

The Harvest Day committee sends postal cards to all the operators of roadside stands and asks them to make continuing contributions of vegetables and fruits. Girl scouts collect donations from door to door. Baskets are placed in all the local grocery stores.

Boy scouts go out into the farm areas and transport donations from the farms to the hospital. School children make posters, and the schools serve as collection centers in the Actons.

The event is advertised in the local papers, and free publicity is given the observance in the newspapers during the late summer. Mrs. S. Russell Clarke Jr. is the chairman.

why send a boy to do a man's job?

DEBILITATED patients need dextrose, certainly. But it's a good bet that their vitamin store is depleted, too.

More and more investigators are realizing that intravenous dextrose *alone* is often not enough to pull debilitated patients over the hump. Sebrell*, for instance, says "By giving glucose, you push up the metabolism and the utilization of those vitamins which are necessary, *without replacing them*. As a result, the suspicion is growing that much of the disability and possibly part of the mortality following surgical operations is due to this effect on a patient with a low vitamin reserve at the time of operation."

When you use Cutter Vitadex-B, you're giving dextrose *plus* 4 of the major B complex factors—thiamine, nicotinamide, riboflavin, and pyridoxine. Also important — patients receive dextrose and vitamins simultaneously, in *one* combined infusion. Physician and hospital staff are involved in only one procedure — making it easier on the patient, and everyone concerned.

*Sebrell, W. H., Jr., et al: J. Pediat. 22:494-507, April, 1943.

CUTTER

Fine Biologicals and Pharmaceutical Specialties

Vitadex-B

Trade Name

CUTTER LABORATORIES · BERKELEY 1, CALIFORNIA

ABOUT PEOPLE

Administrators


Dr. C. W. Munger

Dr. Claude W. Munger, director of St. Luke's Hospital, New York City, since 1937, retired from that position July 1 on account of ill health. **Dr. Lloyd H. Gaston,** formerly Dr. Munger's assistant, was named acting director by the board of trustees.

A past president and trustee of the American Hospital Association and past president of the American College of Hospital Administrators, Dr. Munger was director of Grasslands Hospital, Valhalla, N.Y., for thirteen years before going to St. Luke's. His administrative career began at Columbia Hospital, Milwaukee, Wis., in 1918, two years after his graduation from Rush Medical College, Chicago. In 1921, he became medical director of Blodgett Memorial Hospital, Grand Rapids, Mich., where he remained until he went to Grasslands in 1924.

In addition to his administrative duties, Dr. Munger has been active as a hospital consultant and was director of the graduate course in hospital administration, which he helped to organize at Columbia University.

Elizabeth C. Berrang has been appointed director of the University Hospital of the University of Pennsylvania, and **Edwin L. Taylor** has been named director of the Graduate Hospital.

Dr. Robin C. Buerki has been director of the two hospitals and dean of the Graduate School of Medicine at Pennsylvania since 1941 but will relinquish those posts on July 1 as a result of his election as vice president of the university in charge of medical affairs.

Miss Berrang, who has been associated with University Hospital continuously since her graduation from the school of nursing there in 1922, became assistant to the superintendent of the hospital in 1925 and was made assistant director in 1946.

Mr. Taylor, who has been assistant director of the Graduate Hospital, joined the administrative staff there last year. From 1942 to 1946 he was an officer in the medical administrative corps of the army and served in the Pacific Theater. He was graduated from Rutgers University in 1940 and attended the University of Chicago on a fellowship the following year. Since the war he also has studied in the Graduate School of Hospital Administration at Columbia University.

Paul Fesler, administrator of University Hospital, Oklahoma City, has been chosen to complete the unexpired term of vice president of the Oklahoma State Hospital Association. The post had been unfilled since the resignation of **Paul Smith.**

Kenneth Wallace, president-elect of the Oklahoma State Hospital Association, has been appointed business administrator of University Hospital, Oklahoma City. Mr. Wallace served as administrator of Chickasha Hospital and Clinic at Chickasha, Okla., for nine years prior to his present appointment.

Paul R. Zwilling has retired as administrator of Evangelical Deaconess Hospital, St. Louis. **Rev. Carl C. Rasche** has been named to succeed him.

Norman D. Roberts, former administrator at Perry Memorial Hospital, Princeton, Ill., is now superintendent of Rochester General Hospital, Rochester, Pa.

Dr. Russell E. Blaisdell, superintendent of Rockland State Hospital, Orangeburg, N. Y., since the institution was opened in 1930, is retiring July 1. Dr. Blaisdell has been associated with the New York State department of mental hygiene for forty-one years.


E. L. Taylor


Elizabeth C. Berrang

Capt. William H. Turville has replaced **Capt. William D. Small** as commander of U.S. Naval Hospital, St. Albans, Long Island, N.Y. Captain Turville was formerly commander of the U.S. Naval Hospital at Portsmouth, Va. Captain Small becomes an assistant to the district medical officer of the First Naval District, Boston.

Clifford G. Benson, formerly superintendent of Sister Elizabeth Kenny Clinic at Centralia, Ill., is now superintendent of Sterling Public Hospital, Sterling, Ill.

Willard C. Brinegar, M.D., has assumed his duties as superintendent of the State Hospital at Cherokee, Iowa, a post made vacant by the resignation of **Dr. A. Soucek.** A native of Iowa, Dr. Brinegar is a graduate of the University of Nebraska College of Medicine. He had been acting superintendent of New Hampshire State Hospital, Concord.

Eleanor E. Hamilton is resigning as director of Presbyterian Hospital, Newark, N.J., July 1, after twenty-one years of service. Her assistant, **Marjorie J. Johnson,** a member of American College Hospital Administrators, has been appointed acting director.

Dr. Joseph P. Leone, until recently medical director of the Delaware Hospital, Wilmington, has been appointed administrator of Norwalk Hospital, Norwalk, Conn., to succeed **Robert N. Brough.** A graduate of the University of Rochester and the University of Rochester School of Medicine, Dr. Leone was superintendent of Quincy City Hospital, Quincy, Mass., for eleven years prior to his association with the Delaware Hospital.

John R. Stone, manager of Central Vermont Public Service Corporation at Bennington, Vt., will become administrator of Putnam Memorial Hospital, Bennington, July 1. He succeeds **Dr. Francis J. Bean,** whose future plans were indefinite at the time of his resignation.

(*Continued on Page* 158)

TRUSTEE FORUM

CONDUCTED BY RAYMOND P. SLOAN

FEAR IS NOT A SOUND APPROACH

to Winning the Support of the Public

JOHN B. PASTORE, M.D.

Executive Secretary
Hospital Council of Greater New York

THE ease with which leaders in the hospital field are willing to conclude that hospital facilities and services will be curtailed because of the mounting deficits is alarming to the public. Fear that services may be curtailed does not appear to be the sound approach to obtain support for the voluntary system or to place the public in a frame of mind that will stimulate clear thinking and deliberation. For that reason it is imperative that all individuals responsible for the policies of voluntary hospitals understand fully the facts regarding operating costs and financing of hospitals.

THERE HAVE BEEN CHANGES

Let us consider first the changes that have occurred in the operating costs of hospitals. For purposes of comparison I shall use analyses prepared by the United Hospital Fund of New York for 1940 to 1946 for general hospitals within its membership. The total operating budget of these hospitals increased slightly more than 82 per cent for the years 1940 to 1946. During this same period the average patient day cost increased 62 per cent, while the cost per inpatient increased only 44 per cent. The difference in the increases in these indexes is significant.

These costs are influenced by the total number of patients cared for, the number of patient days of care rendered, and the average length of stay. The average stay was reduced approximately 8 per cent, which accounts for the fact that the cost per patient did not increase proportionately to the increase in the patient day cost. A decrease in the average stay usually increases the per diem cost inasmuch as it reduces the spread for extra charges.

This relation between the length of stay and per diem cost is too frequently overlooked. We might analyze the difference in cost per normal maternity case, depending upon the duration of hospitalization. In every maternity case there are certain required admission and discharge laboratory examinations, in addition to the use of the delivery room. For the purpose of comparison let us assume that the cost for these services remains fixed at $40 per case, and that the cost for room and board and other routine services likewise remains fixed at $8 per day. The variations in cost would be as follows: For a twelve-day stay, the per diem cost is $11.33, and the cost per case, $136; for a ten-day stay, the per diem cost rises to $12, but the cost per patient decreases to $120, and for an eight-day stay, the cost increased to $13.

Thus, by shortening the length of time the patient spends in the hospital we reduce the cost per patient 24 per cent, even though the cost per diem increased 14 per cent. Naturally, the shorter stay is more economical to the patient and to the community, in spite of the increased per diem cost to the hospital.

The reduction in the average duration of hospitalization has also contributed to the marked increase in the operating budget because the hospital can admit more patients. The number of inpatients in the hospitals analyzed increased approximately 21 per cent, although the increase in the bed complement was only 6 per cent. The total patient days increased 12 per cent.

These changes ought not to have a depressing effect. On the contrary, they reflect both progress and economies to strengthen confidence in the voluntary hospitals. These changes mean that hospitals are caring for more patients. They also mean that more patients are being cared for without the double burden on the community of a major capital investment for additional beds and additional operating expense. All hospitals should be proud to have contributed to this progress and to this economy.

HOSPITALS NOT ISOLATED

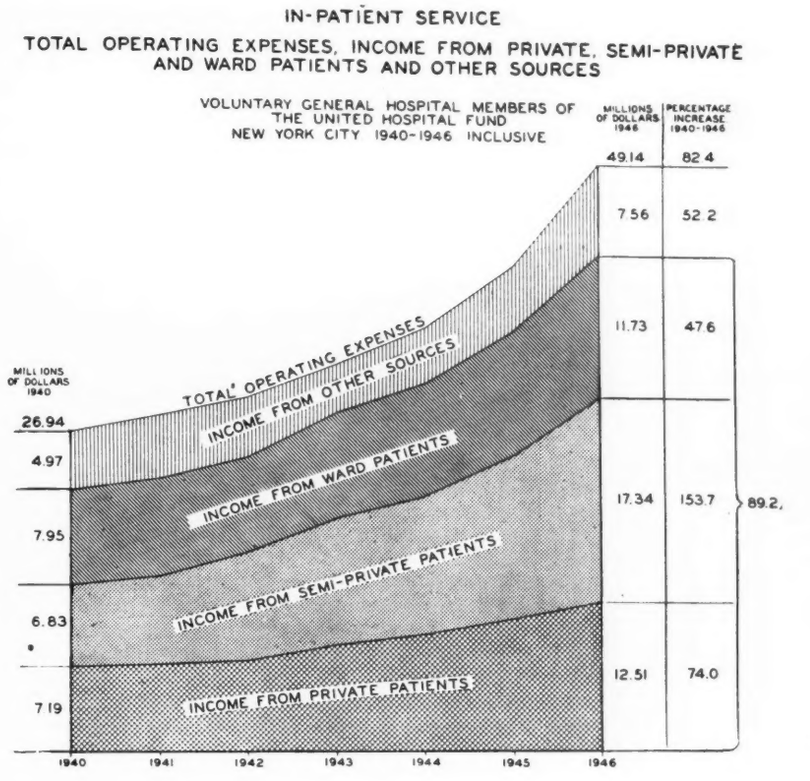
Today we cannot consider hospitals as isolated from the community. In interpreting cost for hospitalization it is desirable to determine the cost to the people and not only to the hospital or the patient. The Hospital Council of Greater New York has studied the use of general care hospitals by the residents of New York City over a period of years. In 1940 an average of 1.21 patient days per person was rendered by all the municipal, voluntary and proprietary hospitals in New York City. However, the average days of general care per person were 1.13 in 1945 and 1.17 in 1946. On the basis of the average cost per diem of $6.55 in 1940 and $10.61 in 1946 (average cost for voluntary general hospitals—U.H.F.), the cost of hospitalization per person in New York City increased approximately 56 per cent, from $7.93 to $12.41. During this period there was only a 1.5 per cent increase in the total number of patient days rendered in spite of the fact that the population increased more than 4 per cent.

The increase in cost for hospitalization to the people is less than the increase in the operating budgets of hospitals or the increase in per diem cost.

Condensed from a paper presented at the New England Hospital Assembly, Trustee Institute, 1948.

This increase in cost to the people is less than 50 per cent, and much of it has gone toward necessary adjustments in salaries paid to hospital personnel. By excluding this cost factor for just a moment we get an even better appreciation of the relatively small increase in total cost. We find that the increase in the cost of hospitalization to the people is also less than the increase in the cost of living and is well below the increases in the cost of many individual commodities.

Why should we be alarmed about a cost which is so obviously within reason? What commodities offer so many benefits—improvements in quality—to balance the increase in cost? Isn't this a positive approach worthy of emphasis when presenting our problem to the public?



WHAT HAS CAUSED DEFICITS?

The next question is obvious. If costs have not risen beyond reason, what has caused the marked increases in deficits? The experience of the voluntary general hospitals within the United Hospital Fund may be indicative of the trends in individual hospitals.

In 1940, operating income from inpatients represented about 82 per cent of the entire budget. Approximately 18 per cent of the budget was the operating deficit financed by income from invested funds and contributions. It will be recalled that the increase in the total operating budget was 82 per cent. During the six-year period, income from patients increased slightly more than 89 per cent, with the result that the portion to be obtained from nonoperating income was reduced to almost 15 per cent of the total budget. In 1940, 18 per cent of the total budget ($27,000,000) amounted to almost $5,000,000, whereas in 1946, 15 per cent of the total budget ($49,150,000) represented slightly more than $7,500,000. The added deficit of $2,500,000 was an increase of 52 per cent.

In our method of financing voluntary hospitals we have expected contributions to make up the operating deficits. In general, the community has met this obligation. It is not beyond reason to expect the community chests and other fund raising agencies to raise their sights and obtain the additional funds necessary to make up the deficit, which actually constitutes a smaller portion of the budget than was the case previously. In a voluntary system as much of the money should be raised by voluntary contribution as is humanly possible.

In our efforts to reduce this deficit we have attempted to obtain more money from the patients. The increase in income from this source substantiates this. Recent analyses, however, would indicate that the average net income or "profit" per private and semiprivate patient day has not increased. Hospitals have depended on this profit to help make up losses on the ward service. Since we are reaching the point of diminishing return, it would be well for us to examine carefully our policy of charges.

A recent analysis of forty-four general voluntary hospitals in New York City revealed an average profit of 37.5 per cent on the private service, or $4.48 per patient day. This "profit" varied from 24 cents per day in one hospital to $11.45 per day in another hospital. The total amount of money (surplus) received from this source is indeed limited. For 1946, the fifty-three general hospitals in the United Hospital Fund collected $4,122,000 in profits from 218,178 private and semiprivate patients. This represents an average contribution of less than $20 per patient. One of the outstanding hospitals of the city received only $61,000 in this form from almost 3500 patients. Yet some of the charges are so exorbitant that patients are "impressed" with the large profits which hospitals make, a factor that is not good for public relations or fund raising. The total amount received from this source constituted only 8 per cent of the inpatient operating budget.

TRUSTEES DICTATE POLICY

Trustees of hospitals dictate the policy for charging patients. It may not be inopportune for us to evaluate the practice of charging some patients more than cost. Not so long ago hospital employes involuntarily contributed to such funds because hospitals paid substandard wages. We all know what a crisis that created. Recently, attempts have been made to obtain above cost payments (charges) from Blue Cross plans. Again, we are familiar with the near catastrophies such policies have created. Although it appears that a solution has been attained, much has been lost since the indemnity plan permits charges to the Blue Cross patient. It would be well for us to avoid another crisis. This is particularly true if we are to expect government and other agencies to pay cost for service rendered to their patients. Under a voluntary system it would appear that even contributions should be on a voluntary basis.

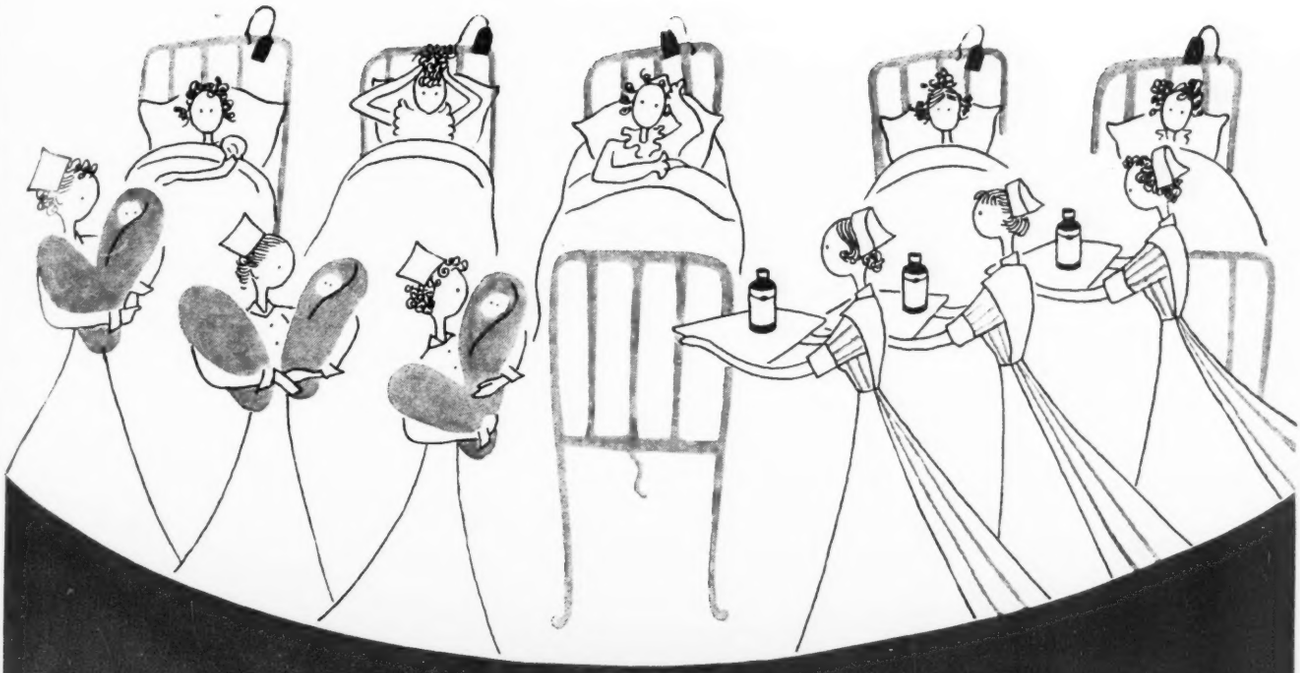
Much of the deficit today is due to losses incurred through services rendered to outpatients. There is no counterpart of private patients in outpatient departments to offset this loss. Consequently, surpluses or "profits" must be obtained from inpatients. Must the inpatients also bear this burden?

There seems to be little use for establishing cost accounting systems in hospitals if charges are not to be related to cost. Hospitals are in a difficult position in trying to justify wide variations in charges. Would it not be better to inform the public as to the full extent of free service rendered and to expect the public to finance this loss?

The analysis presented in this review indicates the need for interpreting hospital costs in terms of the community or population. The increase in cost, which is evidently less than 50 per cent, is well below the general increase in the cost of living. To this knowledge may be added the fact that hospital care has been rendered to more people without the construction of additional beds. This should be a source of comfort and inspiration to those who have made possible increased services to all.

We cannot escape the fact that the operating deficits have increased—the dollar value of free care has increased in proportion with the increase in cost. Serious consideration should be given to the policy regarding charges to private and semiprivate patients in the hope that inequities will disappear and the public will have a better understanding of the cost of hospital care. The individual hospital should expect that at least 15 per cent of its operating budget should be derived from sources other than patient income if the voluntary system is to be maintained. The amount raised by community chests and fund raising organizations should increase proportionately to the overall increase in budget.

There is an increasing tendency to indicate to the ward patient the amount of free service which the hospital has rendered to him. Would it not be just as desirable to indicate to the private and semiprivate patient the amount of contributions which he has made toward the free work of the hospital? Contributions are deductible items for income tax purposes. The private and semiprivate patients are denied the privilege of deducting that portion of their bills which may be considered as a contribution. If patients were given this privilege, increased giving on the part of the public might well be expected.



THE ARDUOUS DAYS

Now that the patients are no longer in a state of anxiety . . . and Junior seems in relatively safe hands . . . mothers' thoughts turn toward rapid return to health and normal activities. Understandably, hospital personnel's thoughts turn toward getting the patient home as quickly as possible.

PRENATAL CAPSULES *Lederle* not only maintain both mother and fetus in vitamin balance during pregnancy, but also accomplish the same purpose for the mother during lactation.

FORMULA:
Each capsule contains:

Vitamin A	2,000 U.S.P. Units
Vitamin D	400 U.S.P. Units
Thiamine HCl (B_1)	2 mg.
Riboflavin (B_2)	2 mg.
Ascorbic Acid (C)	35 mg.
Nicotinamide	7 mg.
FOLVITE* Folic Acid	1 mg.
Calcium (in $CaHPO_4$)	250 mg.
Phosphorus (in $CaHPO_4$)	190 mg.
Iron (in exsiccated $FeSO_4$)	6 mg.
Manganese (in $MnSO_4$)	0.12 mg.

Bottles of 100 capsules.

*Reg. U. S. Pat. Off.

LEDERLE LABORATORIES DIVISION

AMERICAN CYANAMID COMPANY, 30 ROCKEFELLER PLAZA, NEW YORK, 20, N.Y.

MEDICINE AND PHARMACY

PERHAPS THEY ARE NOT INCURABLE

Physical medicine puts a Home for Incurables on the road to becoming a scientific rehabilitation center for chronic diseases instead of just another depository for "hopeless" cases

MEYER J. GILL

Executive Director, Beth Abraham Home for Incurables, Bronx, N.Y.

A MODERN department of physical medicine was installed at the Beth Abraham Home for Incurables, Brooklyn, N.Y., six years ago. The department consists of a large electrotherapy and light therapy room where all facilities of modern electrical treatment are available. It also has a hydrotherapy room which has equipment for medicated and galvanic baths, whirlpool baths, a steam jet, and modern apparatus for colonic irrigations. Massage and corrective exercises are an integral part of the physical medicine program.

The department is under the supervision of the attending physician in physical medicine, Dr. H. J. Behrend. Three technicians and three students from a school of massage constitute the technical personnel, with Miss R. F. Sherman, physical therapist in charge.

In a twelve-month period the department rendered 25,153 treatments, an average of more than 2000 treatments monthly.

INTEREST IN PHYSICAL MEDICINE

After six years of operation of this department the time has come to analyze the results from the administrator's point of view. I cannot help agreeing with John H. Hayes who said, "An administrator must possess a knowledge of hotel management, housekeeping, accountancy, economics and some knowledge of medical practice and law."* As an administrator of an institution devoted to the care of chronic disease patients, I may add that the administrator should have more than a superficial interest in physical medicine because of the good results that have been obtained with it. I discovered within the past few years that methods of rehabilitation are applicable to more than 40 per cent of our cases. Modern medical control, a physiatrist (the name for the specialist in physical medicine recently adopted by the American Medical Association) in charge of the physical therapy department, proper administrative methods within the department, and definite assignments to each physical therapist, all contribute to developing our institution toward the ultimate aim of becoming a scientific rehabilitation center for chronic diseases, rather than solely as a depository for incurable patients. Our physiatrist makes regular rounds, during which he sees all patients referred by the resident staff. All cases are followed up by our medical staff at regular intervals. We have three main classifications of patients, which are referred to the physical therapy department:

Classification 1. Patients who are candidates for rehabilitation.

Classification 2. Patients who seek relief or are aided psychologically.

Classification 3. Bedridden patients with (fecal and urinary) incontinencies.

Classification 1. The patients who are candidates for rehabilitation are those who have suffered cerebral accidents with their resulting hemiplegias; arthritics; old fracture cases; dystonia patients, and spastics. Among the cases referrable to our Home for Incurables, hemiplegias rank the highest in number and are the easiest to rehabilitate. Four methods of treatment are employed:

1. Heat, with infra-red rays and hydrotherapy, also electrotherapy which consists of low volt currents (galvanism and sinusoidal stimulation), and high frequency current (diathermy and short-wave), and finally light therapy (hot and cold quartz).
2. Massage.
3. Corrective exercise and muscle re-education.
4. Teaching of daily activities. Under this classification also falls the development of the unaffected side in a hemiplegic patient.

Our hemiplegic patients are trained to meet emergency situations with exercise, *i.e.* the patient is instructed to lie down on a mat placed upon the floor. He is given a period of time in which to get down and to get up, unassisted. Our physical therapists find that enlisting the patient's imagination as to various emergencies, such as a fire, is far more effective than an ordinary command of "get up" or "lie down." It is explained to the patient, of course, that this is how he would be expected to help himself in a real emergency.

ARTHRITIS RESPONDS FAVORABLY

Arthritis, second on the list of admissions in classification 1, responds favorably to various prescriptions carried out in our physical therapy department. In a great many of our arthritic cases, we find that short-wave diathermy, massage and therapeutic exercise prove helpful. In other cases of arthritis, hydrogalvanism is used successfully in our department. Galvanic bath has shown good results in cases of osteo-arthritis. Iontophoresis is being used more in localized conditions in rheuma-

* Hayes, John H.: Wanted. Mod. Hosp. 68:50 (June) 1947.

toid cases. Perhaps this follows Dr. Joseph Kovacs' theory in Krusen's book, "Physical Therapy in Arthritis." . . . "There is a close relation between chronic arthritis and impaired peripheral circulation with disturbances of the minute vessel circulation most pronounced."

Slow sinusoidal current applied to stiff and painful hands and stiff and painful lower extremities frequently brings desired results. Hydrogymnastics introduced in 1946 have been carried out, despite the handicap of not possessing a pool or Hubbard tank. Our tub has served efficaciously for this purpose, and we are grateful for the several cases that have benefited from underwater exercise.

Classification 2. The patients who seek relief or are aided psychologically are multiple sclerotics, parkinsonians, paralytics and quadriplegics. We have many patients with a diagnosis of multiple sclerosis or Parkinson's disease who depend upon the department for the abortion of pain. Despite the fact that many of these neurological disorders come to the department only for relief of pain, we have been able to chart certain observations that have led us toward definite routine in the individual cases; these observations we hope to be able to publish later on.

For instance, one multiple sclerotic patient has been able to become rehabilitated sufficiently to be placed with the group of emergency trainees. Another condition that has stimulated our interest is dystonia; there has been complete rehabilitation of a patient who had been in a wheel chair for twenty-seven years. As a result of intensive physical therapy, this patient now walks with the aid of a cane and conducts our canteen, even handling his own inventories and accounts.

Classification 3. One of the most pressing problems in an institution for chronically ill patients is the one of decubital ulcers. Quoting Dr. S. Ritter, our attending physician in urology, and Dr. A. J. Begner, the associate in urology, "The incontinent patient who lies in a hot poultice of urine and feces and whose tissues are going through a constant process of devitalization becomes inevitably a victim of decubital ulcers." We feel that we have solved this problem to a large degree by using preventive measures, early treatment, and requisitioning meticulous reexaminations periodically.

Preventive Measures

1. All incontinent patients are bathed and changed as often as needed and as often as nursing schedule permits.

2. All bedridden patients, who are medically able, are taken out of bed every morning, dressed and wheeled out onto solariums.

3. Patients unable to be transported from bed, owing to high temperature or acute illness, are turned often, and routine back care is given.

Early Treatment

All pressure sores, abrasions and reddened areas are treated at the onset, and decubital ulcers are treated with cold-quartz irradiation and are aseptically dressed daily.

Meticulous Reexamination

All discharged cases of decubital ulcers are reexamined daily, and the physical therapy department is promptly notified of any reoccurrences. We have solved this entire problem by assigning one physical therapist for reexamination or follow-ups and for daily treatments. This is accomplished by cold-quartz irradiation; a member of the nursing staff is assigned to aseptic dressings. Of the approximately 125 incontinent patients, our decubital ulcer cases, that include all minor abrasions,

have never been in excess of twelve. Before concluding this paper, I feel that a statement regarding qualifications for physical therapists dealing with chronically ill patients should be made.

It is most desirable that the technician should have the standard training required by the registry of the American Congress of Physical Medicine because the prerequisites of this training include a thorough knowledge of the corrective exercise and rehabilitative program.

The most elaborately equipped department and the most highly professionalized background, however, are of no value if the personality of the physical therapist is forbidding. Rigid dignity and reserve unfortunately often fail to gain the confidence of the chronically ill patient who often feels alone and friendless. A sense of humor, patience, warmth, good nature, and, above all, enthusiasm are assets that cannot be stressed too highly. An attitude of "nothing will help them" must be discouraged as it accomplishes only two purposes: a sense of frustration for the physical therapist and a transference of discouragement to the patient. Unless a physical therapist possesses the traits mentioned she had best forget chronic or any rehabilitative work.

Six years of scientific and rehabilitative work in physical medicine resulted in the discharge, the first time in the history of the institution, of eleven patients who had been considered incurable. Although the number is comparatively small, it is a tremendous achievement because patients admitted to the institution for terminal custodial care have been able to go home and live useful lives with their families. This fact shows the importance of the problem for the community.

NOTES AND ABSTRACTS

Prepared by the Committee on Pharmacy and Therapeutics. University of Illinois College of Medicine, Chicago 12

Treatment of Periodic and Common Headaches

FOR purposes of brevity specific head pains, such as facial neuralgias, psychoneuroses (atypical pains), earache and toothache, will be omitted from this review. While these pains occur in the head, they are usually due to a determinable cause and are relieved by specific measures rather than by drug treatment. Certain headaches accompanying such organic diseases as brain tumor and uremia will be included but not discussed, since in these instances the differential diagnosis is of paramount importance.

Intracranial Pain Receptors

The only sensitive structures inside the cranial vault are the basilar portions of the dura mater, tentorium, falx cerebri, and the blood vessels. The gray and white matter may be cut or cauterized without pain. The skin of the head may be completely anesthetized with procaine, and headache can still be induced. Ligation of the superficial arteries does not alter headache. Pain is localized to the deep arterial walls and the supporting structures of the brain. The afferent impulses are carried over the fifth nerve for the anterior and middle meningeal arteries.

The posterior meningeal artery receives its nerve supply from the tenth and twelfth cranial nerves. Alcohol injections indicate that the fibers of the first division of the trigeminal nerve are chiefly concerned with the mediation of headache. Occasionally, however, the sensory nerve roots as low as the second or third cervical and all of the cervical sympathetic nerves must be severed to relieve intractable headache.

Experimental Headaches

Nitrite Headache.

If 15 mgm. of glycerol trinitrate is rubbed on the skin, or 1 to 2 mgm. is applied sublingually, a headache that may last twenty-four hours will result in certain individuals. Tolerance is quickly established to this headache. The acute headache occurs after the blood pressure has recovered from the marked drop produced by the nitrites.

Histamine Headache (Pickering).

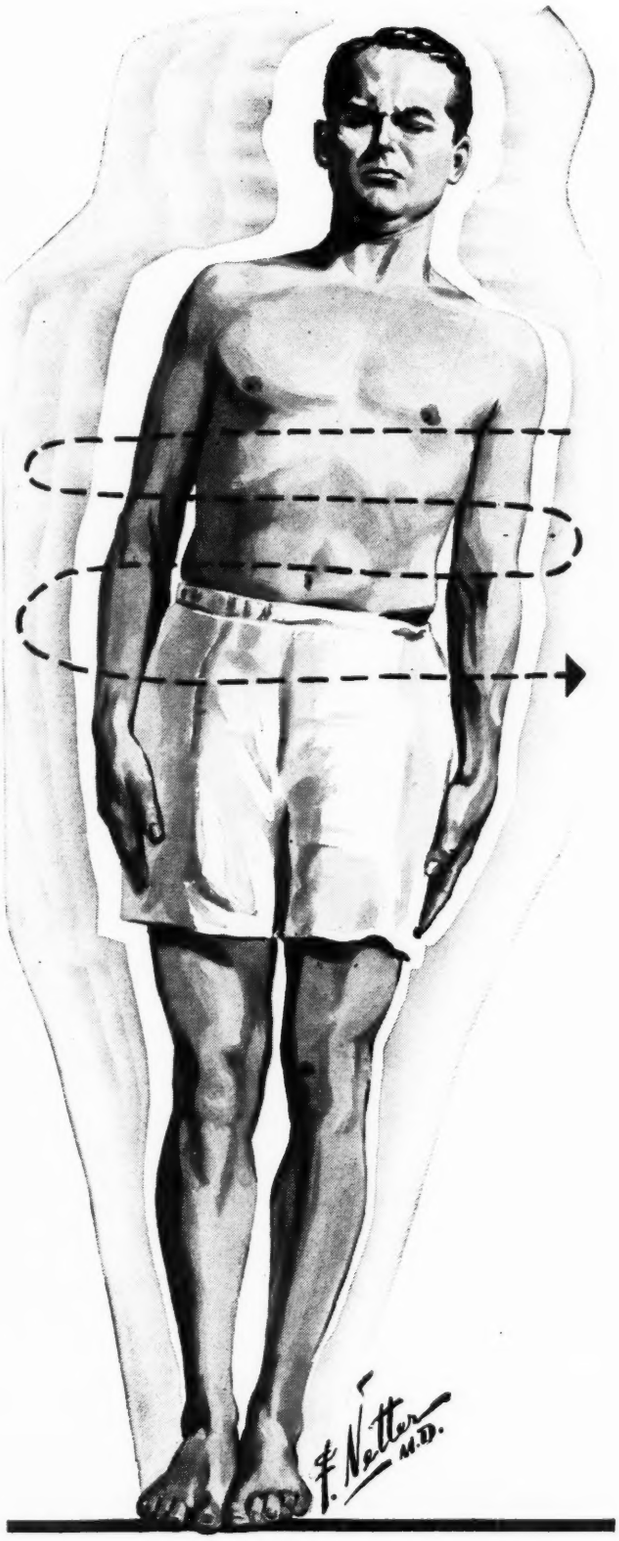
If 0.1 mgm. of histamine is injected intravenously into any individual, a severe bilateral throbbing headache will appear in about two to three minutes and will last about five minutes. The headache does not occur during the drop in blood pressure accompanying the initial histamine shock. The pain can be definitely correlated with a rise in blood pressure above the initial level. If this is counteracted by continuous histamine infusion, the headache is prevented temporarily. Many physiological procedures, such as bilateral jugular compression, which affect the cranial blood supply and raise the cerebrospinal fluid pressure will relieve the headache. In the case of Horton's headache a subcutaneous injection of histamine produces the syndrome.

Caffeine-Withdrawal Headache.

Many individuals will develop a headache if they do not obtain their morning cup of coffee. Making use of this observation, experimental headaches may be produced by giving subjects increasing doses of caffeine. Placebo capsules are then substituted on the fifth to seventh day of caffeine administration. The subject will feel depressed in the morning, and in the early afternoon a headache starts which reaches a maximum about 4 to 6 p.m. Nausea and vomiting may also occur with this type of headache. It is possible to induce this headache in 60 to 70 per cent of normal individuals.

Hypertensive Headache.

If neosynephrin is given intramuscularly in doses of 10 to 15 mgm. to normal individuals, a severe headache will occur when the blood pressure is elevated. Ephedrine will also produce headache in overdosage. These headaches are perhaps strictly comparable to hypertensive headaches.



POSITIVE ROMBERG

A positive Romberg test (Brauch-Romberg symptom) is one of the more characteristic evidences of cord involvement in pernicious anemia. Because of impaired position sense, the patient sways from side to side when he stands with feet together and eyes closed.

Early, adequate and persistent therapy is essential for the prevention or control of spinal cord affection in pernicious anemia. This is most important since neural involvement may cripple or incapacitate the patient. The *quality* of the liver preparation employed thus becomes of utmost significance. In the production of ARMOUR LIVER PREPARATIONS every precaution is taken to assure therapeutic efficacy. The ARMOUR LABORATORIES has available the world's largest supply of fresh raw animal material. Skill and care are exercised to preserve the active blood regenerating constituents of the fresh liver—the hemopoietic principle as well as secondary factors. The finished products are tested for potency on actual pernicious anemia patients in relapse.

Have confidence in the preparation you prescribe—specify "ARMOUR"

ARMOUR *Liver Preparations*

Liver Liquid Parenteral
4 U. S. P. Injectable Units per cc. 1 cc., 5 cc., and 10 cc. rubber-capped vials. A preparation retaining the secondary hemopoietic factors and most of the vitamin content of the liver.

10 U. S. P. Injectable Units per cc. 1 cc., 5 cc. and 10 cc. rubber-capped vials.

15 U. S. P. Injectable Units per cc. 1 cc., 5 cc., and 10 cc. rubber-capped vials. A highly refined and concentrated preparation for massive dosage.

Solution Liver Extract—Oral
45 cc. equal 1 U. S. P. Oral Unit. A readily assimilable and therapeutically effective preparation for use when the oral route is indicated or preferred.

Liver Extract Concentrate—Capsules
9 capsules equal 1 U. S. P. Oral Unit. Odorless and tasteless. Sealed gelatin capsules in boxes of 50 and 100.

ARMOUR *Laboratories*

CHICAGO 9, ILLINOIS • HEADQUARTERS FOR MEDICINALS OF ANIMAL ORIGIN

Carbon Monoxide Headache.

The mechanism of this headache has been studied extensively by Swedish scientists and by Von Oettingen at the National Institute of Health. A rise in CSF pressure has characteristically accompanied the headache and it appears that this is the only one of the experimental headaches which shows this phenomenon.

Relaxation Headache.

In subjects who are susceptible to this type of headache it is possible to reproduce it consistently by having them follow a daily cycle of increased activity and decreasing sleep. The headache is then precipitated by having them sleep late. This may be the characteristic Sunday headache of the business executive or the post-examination headache of the student.

Fever Headache.

Schumacher has found that with fever therapy the headache is accompanied by an increased excursion of the cerebral blood vessels. Many febrile diseases may have severe frontal headache as their initial symptom; of these the typhus group (rickettsial type) is the most important.

Differential Diagnosis

Definite Types.

1. Eyestrain headache—frequently occipital or even nuchal. Relieved by adequate correction or rest.

2. Empyema of nasal sinus—usually accompanying a cold. Requires x-ray diagnosis to be accurate. Migraine and Horton's headache are frequently accompanied by a nasal discharge, which may confuse diagnosis.

3. Brain tumor—morning headache (frontal or generalized) and change of posture intensifies. Sitting up in bed in a.m. may cause projectile vomiting.

4. Post-spinal puncture headache—decreased CSF pressure. Horizontality is best treatment, does not respond to gynergen, but oxygen aids headache.

5. Hypertensive headache—worse in morning and disappears by noon (bursting headache). Treatment with "head-up bed" may be effective.

6. Migraine headache—twice as frequent in female. Unilateral, familial, scotomatous, periodic and accompanied by nausea and vomiting. Onset at puberty with relief at menopause—frequently with hypertension. Relieved by pregnancy, occurs frequently with menstrual period, occurs periodically with relaxation, frequently preceded by diuresis, 90 per cent respond to gynergen (ergotamine tartrate) or DHE-45 if given early in syndrome.

7. Horton's erythromelalgia—age 30 to 40. Sudden onset and relief, unilateral lacrimation and rhinitis, local vasodilatation. Produced by histamine and relieved by raising tolerance to histamine or by use of antihistamine drugs.

8. Post-traumatic headache—resulting from trauma following head injury without rest. Patient should stay with head up or head down.

9. Psychoneuroses—patient complains of pulling sensation, headache on top of head, tight band around head; also headaches are frequently associated with schizophrenia.

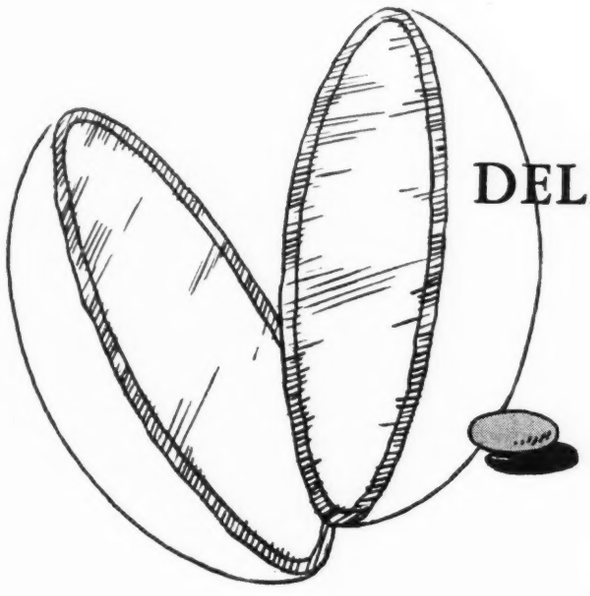
10. Toxic headache—carbon monoxide and lead poisoning, frontal headache of fevers. Nitrite poisoning, chronic tobacco poisoning.

11. Alcoholic hangover headache—varies with each individual but may be due in some instances to the marked changes in water balance that alcoholism induces.

12. Caffeine-withdrawal headache—as induced experimentally can be relieved with caffeine, benzedrine or oxygen therapy. Probably the reason most proprietary medicines contain caffeine.

13. Relaxation headache—probably

PYRIBENZAMINE *in a NEW form . . .*



DELAYED ACTION
TABLETS

FOR NIGHT-LONG ALLERGIC RELIEF

Many allergic patients may now receive symptomatic relief throughout the night. Delayed action tablets of Pyribenzamine are protected by a special coating so that the drug is not released for absorption until approximately the time an uncoated tablet ceases to be effective (4 to 6 hours). Sufferers from hay fever, urticaria, or atopic dermatitis can usually obtain night-long relief by taking one uncoated tablet of Pyribenzamine with one delayed action tablet at bedtime.

Pyribenzamine; scored tablets 50 mg., elixir 5 mg. per cc. (Council Accepted)

- Pyribenzamine delayed action tablets 50 mg. (Not Council Accepted)

Ciba

PYRIBENZAMINE (brand of tripelennamine) Trade Mark Reg. U.S. Pat. Off.

CIBA PHARMACEUTICAL PRODUCTS, INC., SUMMIT, NEW JERSEY
2/1373M

the cause of the Sunday headache in the business world, Monday headache of the clergy, and day-off headache of the nurse. May be due to peripheral vasodilatation.

Indefinite Types.

1. Hunger headache—going too long without food results in headaches that may or may not be relieved by eventual food intake.

2. Excess starch or sugar headache—corrected by diet containing mainly the vegetables that grow above the ground.

3. Food allergy headache—chocolate, onions, watermelon, cabbage, cucumber, garlic, green pepper, peanuts and possibly milk are the commonest offenders.

4. Hypotensive headache—orthostatic hypotensive syndrome. Fall in blood pressure on standing accompanied by syncope and headache. Treatment by "head-up bed."

5. Mountain or altitude sickness (as in aviators)—acute oxygen-want.

6. Headache due to unaccustomed exposure to a bright sun—may be a relaxation type of headache with peripheral vasodilatation.

7. Headache accompanying epilepsy, eclampsia, bleeding peptic ulcers, Addison's asthenia, cerebral syphilis, and myxedema.

Mechanism of Migraine

Lauter Brunton suggested near the close of the nineteenth century that the cerebral blood vessels must be involved in migraine headache inasmuch as he was able to obtain relief of his unilateral headache by carotid pressure. Ray, Graham and Wolff in 1937 demonstrated adequately that the headache is associated with an increased excursion of the cerebral blood vessels, and when the headache is relieved by ergotamine tartrate the excursion of the blood vessels decreases.

Theoretically, an increased excursion of the cranial blood vessels could result from an increased arterial blood volume, decreased blood volume, increased blood pressure, decreased blood pressure, increased cerebrospinal fluid pressure, and finally a decreased cerebrospinal fluid pressure. Most migraine headaches are perhaps accompanied by a decreased blood volume with a relaxed peripheral vascular tone. Therapy should, hence, be directed at increasing the peripheral vascular tone (ergotamine tartrate) or increasing the blood volume (salt mixtures or hypertonic I.V. solutions).

Therapy of Acute Migraine

The ascribed etiology and resultant therapy of migraine and most recurrent headaches depend on the specialist consulted. The endocrinologist is likely to ascribe much of migraine to endocrine deficiency; the allergist claims a high percentage of these cases when he diagnoses the condition, and the psychiatrist is likely to apply psychotherapy for all types of headache. In most cases the interested general practitioner or neurologist achieves the best subdivision of the migraine syndrome so that the patient obtains the proper therapy for his particular case.

Ergotamine Tartrate or Dihydroergotamine (DHE-45).

Either 0.3 cc. intravenously, or 0.5 cc. to 1.0 cc. of 1-2000 gynergen intramuscularly, if given at the onset of an attack, will result in relief in one to two hours in 90 per cent of the patients (use twice as much with DHE-45). Atropine 0.5 mgm. may aid nausea and vomiting produced by gynergen, and calcium gluconate (10 cc. of 10 per cent) may relieve the muscle cramps produced by gynergen. If oral treatment (which is not nearly as effective) is attempted, the

1 mgm. tablets should be placed under the tongue until completely dissolved. This may be repeated once or twice in twenty-four hours without danger of poisoning. If 2.5 to 10 mgm. of benzedrine sulfate or 100 mgm. of caffeine (Horton) is combined with the oral dose, more effective relief is obtained, possibly because of synergism in the peripheral vasoconstricting action.

Analgesic Prescription (Proprietary).

Acetphenetidin	2	0
Acetyl salicylic acid	4	0
Caffeine citrate	1	2
*(Codeine phos.)	0	8

Put in capsules # 24.

Sig. Take one or two capsules at first sign of headache.

* May be added depending on severity of attacks.

Oxygen Therapy.

From 6 to 8 liters per minute flowing 100 per cent through a Boothby or nasal mask may abort an acute attack if taken early enough.

Antihistamine Therapy.

Some migraine patients receive marked relief of their syndrome after benadryl or pyribenzamine therapy. A few can be relieved by means of parenteral papaverine therapy (60 mgm. intravenously).

Sodium Nicotinate.

This may relieve the migraine syndrome in selected cases. Goldziecher and Popkin claim 75 per cent effectiveness with 100 mgm. injected intravenously.

Octin.

From 100 to 200 mgm. of octin, given subcutaneously, is also credited with relief of the acute migraine syndrome.

Barbiturates.

These may be effective in producing sleep in spite of the migraine syndrome, and the patient may be free of the attack when he awakens.

Supportive Therapy to Prevent Migraine Attacks

Thyroid Therapy.

Even with a normal basal metabolism rate, migraine patients are frequently relieved by thyroid therapy. Adequate tests must be made from time to time to avoid thyroid overdosage.

Calcium Gluconate or Lactate—3 Teaspoons Daily.

Particularly useful in patients who show a decreased serum calcium and elevated serum phosphorus.

Calcium Lactate—KC1 Therapy.

Same proportion of these ions as is present in the blood serum based on the theory that this proportion is necessary to increase the blood volume. Gr.X of mixture taken T.I.D. after meals. Mixture consists of 308 Gms. of calcium lactate to 225 Gms. of potassium chloride. Sixty per cent success in treatment of migraine with this mixture. While it is better as supportive treatment, it may also be used in acute attacks.

Diet Therapy.

The best dietary treatment has been found empirically to consist of a low carbohydrate diet.

Histamine Infusion to Raise Tolerance.

Since histamine is a pure chemical, patients are not desensitized to histamine but do have their tolerance raised to its pharmacodynamic effects. While this is used extensively, we do not as yet have controlled studies on its effectiveness.

Menstrual Migraine.

This can sometimes be prevented by either ammonium chloride therapy started ten days prior to menstruation or progesterone and estrogen therapy started three to four days before the onset of the menses.

Phenobarbital.

In sedative doses phenobarbital may be effective in those patients whose attacks occur when they become unduly excited.—C. C. PFEIFFER, M.D.

FOOD SERVICE

Conducted by Mary P. Huddleson

VISUAL AIDS TO INSERVICE TRAINING

HELEN CAHILL
Chief
Dietetic Section
Veterans Administration
Branch Office 12
San Francisco

EMPLOYE training, an important feature in the program of the Veterans Administration, is being emphasized with the development of training courses for its dietetic personnel. That progress has been made in these educational programs is evidenced by the number of courses being given to supplement on-the-job training at the various Veterans Administration hospitals, either as a part of each hospital's training program for its employes or as branch office or central office activities which include courses for groups of certain dietetic personnel from the whole branch area and possibly an adjacent branch area.

The ever increasing work load in many of the veterans' hospitals and the rapid turnover of employes, the majority of whom are brought on the job without previous experience or training, made apparent the need for a method of orientation for these inexperienced workers. Recognizing this need, the dietetic section of the V.A. Medical Service in Branch Office No. 12, San Francisco, has made training of the food service worker a major project during the last eighteen months.

It was decided that the purpose of this project should be to give food service workers a fundamental understanding of the basic rules of health and sanitation which are so vitally necessary for the safeguarding of the patients and themselves.

With this objective in mind, the dietetic section, in collaboration with the Training Division of the Personnel Service, made a study of the most effective ways to meet the situation. Problems to be considered were discussed, tentative plans were adopted, and a distribution of responsibility was made. The Training Division submitted a rough draft of procedure based on the technical material provided by the dietetic section.

Further research with on-the-job analysis of the worker's job was made by visits to nearby hospitals. Here the worker and situation were observed at first hand by a qualified training officer, a dietitian and a visual aid specialist. Following these visits the material developed was submitted to the dietetic section for necessary revision and modification.

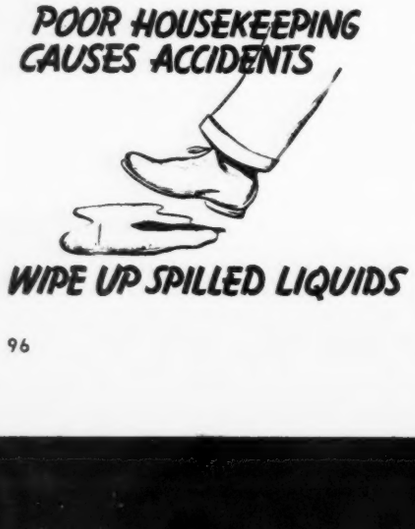
The final program consisted of two parts: (1) the Supervisory Training Course and (2) the Food Service Workers' Course. The course for supervisory personnel precedes the course for food service workers on the assumption that the supervisors should first qualify in on-the-job training technics before instructing personnel.

In developing this course for use in all the hospitals in the branch area, it was hoped to assure basic coverage of particular training needs by giving wide latitude to the hospitals in adapting the course to local situations. The dietetic section assisted with the technical editing, while the Training Division assumed much of the detail work and organized the material into an acceptable instruction format.

On the assumption that the food service worker can more readily acquire information from visual aids than he can from the printed or spoken word, a series of eighteen or twenty charts was developed to supplement the material of the syllabus. Particular problems were noted by the dietetic section or suggested by the hospital staff and visualized by the training specialist. Additional charts will be prepared as the need arises and as "problem situations" are presented. It might be added that colored slide films have been made of all charts, and each hospital has received a set.

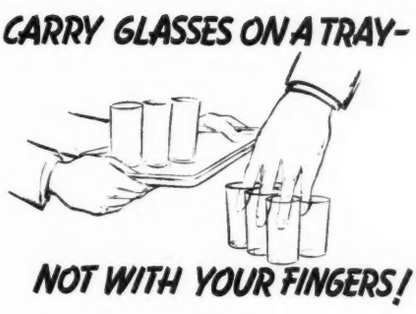
Training films were reviewed by the two sections, and those determined to be acceptable were keyed to respective phases of the course. Examples of job breakdowns, the key points of instruction and important steps being noted, were developed to cover jobs ranging from the serving of trays to the separation of food waste. Through these guides it was believed that uniformity of instruction in the branch area would best be achieved.

With much of the groundwork laid, the acting deputy administrator, the assistant deputy administrator, and the branch medical director were asked to review the work completed. Their marked enthusiasm gave assurance that the course met with approval, and that



each hospital would be supplied with charts, films and any other tools deemed necessary to conduct this essential training.

The chief of the dietetic section and the chief of the Utilization and Training Division conducted appreciation sessions of this program in four of the hospitals. Where it was impossible to present the material in person, complete coverage of all phases of the training was sent out. Stations have been encouraged to adapt the program in any way necessary to serve their local needs best. Records of accomplishment are maintained and submitted to the branch office. Every effort is made to assist the hospital whenever necessary, and visits are made from time to time to observe training progress. An exchange of materials and ideas makes it possible for all stations to benefit from the accomplishments within the branch area.



Through the combined efforts of the dietetic section and the Training Division, one responsible for technical content and the other for organized approach and method, a program assuring a high standard of employe training throughout Branch No. 12 area has been developed. We are confident that the time and effort devoted to this course have provided, and will continue to provide, a more efficient, stable and satisfied work force.

THE QUALITY OF SERVICE
Comes Back to Good Administration

ANTHONY W. ECKERT

Administrator, Fitkin Memorial Hospital, Neptune, N.J.

THE influence of the dietetic department is felt in every other area of the hospital. Therefore, we must set our standards high by having a well trained and well qualified dietitian as head of the department. She should be selected carefully on the basis of education, training, experience, personality and adaptability for the particular type of hospital in which she is employed.

Furthermore, on the basis of my experience as director of the dietetic school of Fitzsimons General Hospital in Denver, I believe that the chief dietitian should first have had training as an assistant. The responsibilities of the chief dietitian are so great that many times the novice becomes discouraged, and we lose a potentially capable hospital dietitian because she has not had sufficient experience as an assistant.

PROBLEMS WILL GROW

Many of us have tended to disregard the dietetic department and to let it run by itself. It can do so for a short time, perhaps, without the support and interest of the administrator but it cannot run unsupervised for long without developing problems—real ones. This department has been neglected for many years, for an inferior type of personnel has often been assigned to it, it has been given inadequate space and poor equipment, and often is improperly located. This tendency is a thing of the past. We now recognize the importance of this department and the value it has to all concerned.

Good food service is an asset and the reputation of rendering poor food service can too readily be acquired in the community, with consequent detriment to the hospital. Build a good food service. Give it proper recognition and support, and the status of the department in the hospital will become a vital part of the professional care of the patient, psychologically as well as for its therapeutic value.

The administrator should give the dietetic department close supervision. He should give his head dietitian a clear picture of the general organization plan of the hospital and a definite plan of organization of her own department. Conferences and guidance are always welcome and help promote a more smoothly functioning department.

The organization of the department should be set up with clearly defined lines of authority from top to bottom and also lines of authority as they affect other departments. There is nothing so bad for an institution and its morale as lack of organization and policies that are not clearly outlined.

NO TWO ARE ALIKE

It would be impossible to suggest an exact form of organization to fit the needs of all hospitals because no two institutions or their problems are exactly alike. Fundamentally, however, any department such as the dietetic service can conform to certain basic principles of organization applicable to all. We could follow a pattern, such as the following, in order to function more efficiently, coordinate with all other departments, and thus create better interdepartmental relations. Such a pattern would demand, first, an efficient chief or head dietitian; second, a good assistant dietitian; third, a closer relationship with the administrator; fourth, a clear cut organization plan, both of the hospital and of the department, and fifth, a sound operating schedule.

In order to improve interdepartmen-

tal relationship, it is expedient that full authority be delegated to the chief dietitian. She should be responsible for the entire management of the department. In her training she will have acquired a knowledge of institutional management, quantity cookery, wholesale food buying, and personnel management. Her experience before becoming chief dietitian should make her a valuable member of the staff. Her authority in all functions is highly important, because each meshes into the other, making a complete whole in daily operating efficiency.

The application of scientific management principles is essential if the sciences of food and nutrition are to be effective in large group feeding. I continually stress the importance of the dietitian's direct authority because this is the crux of good interdepartmental relationship. If one's sphere of authority is not clearly defined, it is like having a broken link in the chain and can result only in confusion and inefficiency.

The dietary department, nursing department, and medical staff are directly concerned with therapy. Their duties are closely related, and the utmost cooperation, harmony and coordination are therefore essential. The relationship between these sections is often severely strained, and frequently one will find the director of nurses trying to assume authority over the dietitian. This should not be permitted. Greater harmony can be expected if the director of nursing and director of dietetics look to the administrator for guidance and authority in all matters.

CAN OVERCOME FRICTION

It is regrettable that friction frequently exists between the director of nursing and the chief dietitian. This can be overcome if the major problems regarding food or food service are cleared at staff conferences instead of these two department heads having to run back and forth to each other.

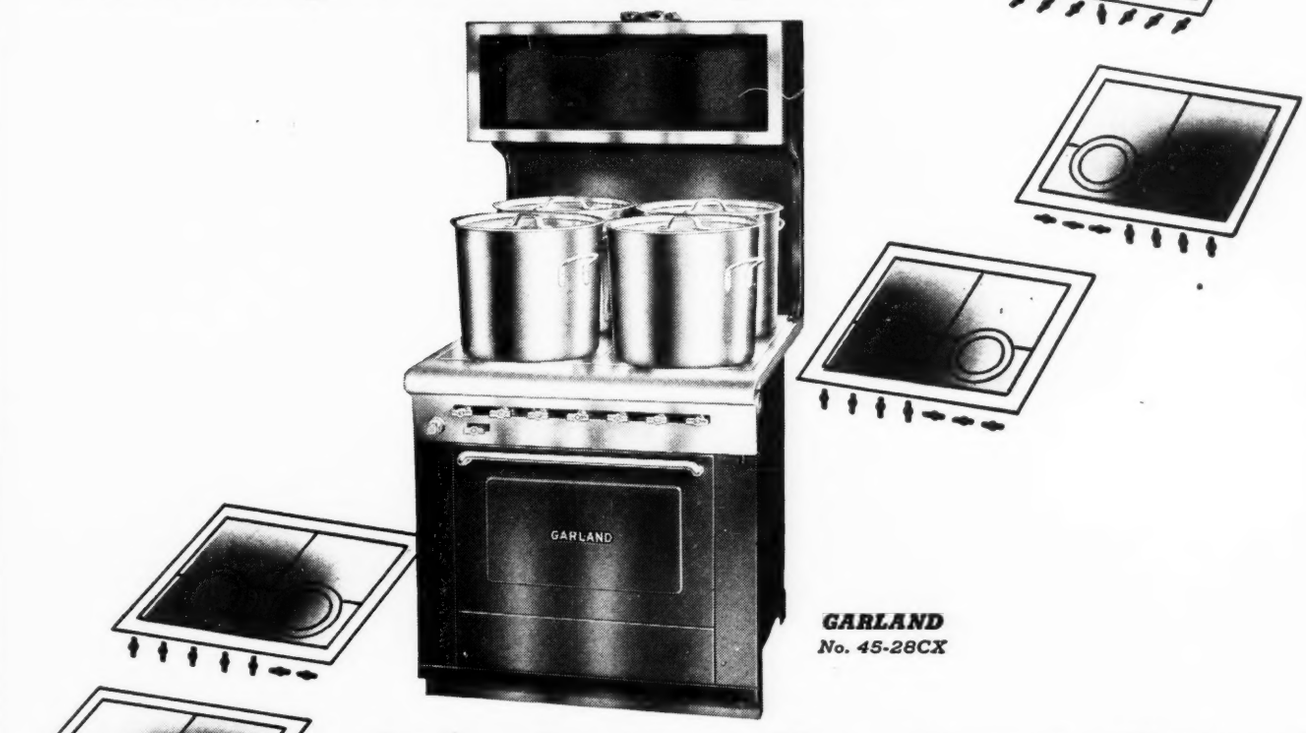
The director of nurses must have an understanding of the objectives of the dietetics department to assure its success. This is important because we know that in most hospitals the food service personnel is not adequate to complete every function of the department. The nurses, for example, usually must help with the preparation of the patient for feeding and in many instances assist in serving the tray to the patient.

Without the director of nurses' interest, understanding and sympathy, little can be accomplished for good food service to the patient. It is therefore necessary that conferences with the nursing department and the dietetic department be held frequently. We should always keep in mind the need for an attractive food service that will do much to help patients who usually have little interest in or desire for food.

The relationship between the dietary department and the medical staff also needs serious consideration. It is unusual in many hospitals for the doctors to take time to discuss the patient's diet with the dietitian. Rarely does the doctor find his way to the dietitian's office, and more rarely still does he call the dietitian to the patient's bedside for diet consultation. The doctor is usually too

Only the Leader

Gives the User Such Flexibility of Cooking Top Heat



GARLAND
No. 45-28CX

Only Garland Has *Front-Firing!*

Seven individually controlled burners—all **front fired**—give you an infinite number of heat variations on the Garland Hot Top. The chef gets *any heat* he wants—*where* he wants it—*when* he wants it! He can prepare better food. He can do it faster. He can save fuel. He can help reduce the cost per meal served. Available for manufactured, natural or L-P gas. Consult your Garland Food Service Equipment Dealer. He is an expert advisor!

GARLAND*

THE TREND IS TO GAS FOR ALL COMMERCIAL COOKING

Heavy Duty Ranges • Restaurant Ranges • Broilers • Deep Fat Fryers • Toasters
Roasting Ovens • Griddles • Counter Griddles

PRODUCTS OF DETROIT-MICHIGAN STOVE CO., DETROIT 31, MICHIGAN

*REG. U. S. PAT. OFF.

casual or indefinite in giving diet instruction.

What can we do about it? Administrators know that the medical staff needs to be constantly checked up concerning daily problems, and the best way to give it the proper instruction is at the monthly staff meetings when the doctors are all together. Better yet, the chief dietitian should be permitted to present her point of view for five or ten minutes at the monthly staff meeting. It works—and helps.

The habit of many doctors of making rounds at or during mealtimes is a major problem in many hospitals and results in meals being served cold. This can be avoided by enforcing a strict rule regarding doctors making rounds during meal hours. Some doctors are persistently troublesome and will not cooperate.

Good results have been obtained by giving instructions to the nursing department that during meal hours nurses will not make rounds with doctors and that they should serve the trays to the patients regardless. From time to time we get out a little notice to this effect, and a copy is sent to all staff doctors. Just don't let the doctors get into the habit of using the word "emergency" too often. This habit will definitely impair the efficiency of your food service.

Another serious problem is the special or private duty nurse. Often, in an effort to please the patient, these nurses violate many rules of the hospital—especially when they concern the dietary department. They want late trays served, early trays, or special food items, and they think they have almost a prior right to the full use of the dietary department, its equipment, and supplies.

We have discovered that private duty nurses often feel called upon to comment unfavorably on the appearance and quality of the patient's trays in the presence of the patient. These comments may be innocently made, but there can be no doubt that they have a very poor psychological effect on the patient.

This situation, too, can be corrected by having sound policies regarding the food service and supporting your dietitian in enforcing the rules. Private duty nurses can be restrained from disrupting the food service. The administrator should speak to the nursing alumnae, who usually make up the private duty group, at least once a year—bringing forcibly to their attention these important issues.

SHOULD MAKE ROUNDS

The administrator should make periodic rounds with the dietitians, especially when they are visiting patients. Many interesting matters will be discovered on these rounds which usually can be constructively applied for a better food service. The administrator should also make periodic inspection of the complete food service from the food preparation, cooking, and setting up of trays to the serving of the food to the patient.

Here, again, numerous things of interest will be discovered. These inspections will do much to improve the department, because all other departments and employes concerned will observe that the administrator is vitally interested in the food service.

Full cooperation among the dietetic staff, physicians, nurses and housekeeping department and the wholehearted support and guidance of the administrator are essential to an efficient diet service. Indifference on the part of members of the organization is likely to reduce the quality of service to the patient and employes.

Menus for July 1948

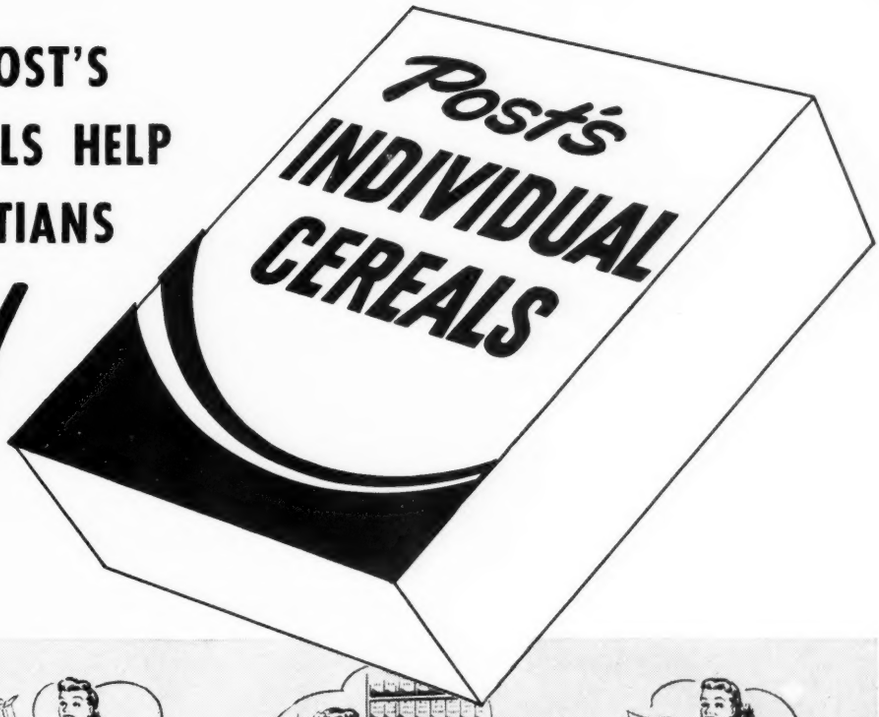
Elizabeth Anderson
Charlotte Memorial Hospital
Charlotte, N.C.

1	2	3	4	5	6	7	8
Grapefruit Juice Bacon * Roast Beef Mashed Potatoes Eggplant Creole Lettuce,1000 Is.Dr. Spiced Applesauce * Asparagus Cheese Dream Fresh Butter Beans Gelatin Fruit Salad Cottage Pudding, Orange Sauce	Tomato Juice Scrambled Eggs * Creamed Salmon and Peas on Rice Julienne Carrots Pineapple Salad Angel Cake * Swiss Steak Parsley Potatoes Harvard Beets Sweet Pickles Fresh Fruit Cup	Orange Halves French Toast * Lamb Chops Broiled Tomatoes, Cheese Sauce Stewed Corn Cole Slaw Banana Pudding * Spaghetti with Meat Balls Fresh Mustard Greens Celery Hearts Dried Apricots	Watermelon Wedge Bacon Poached Egg * Roast Pork Sweet Potatoes with Marshmallows Buttered Asparagus Apple Salad Cherry Ice Cream * Pineapple Cream Cheese Sandwich Tuna Salad Carrot Sticks Chess Pie	Grapes Soft Boiled Egg * Baked Ham Pumpkin Puff Brussels Sprouts Olives on Lettuce Fresh Peaches, Cream * Chicken a la King on Rice Black-Eyed Peas Sliced Tomato Sal. Cookies	Orange Juice Bacon * Fried Eggplant Escalloped Tomatoes Fresh Kale Fruit Salad Brownies * Welsh Rabbit on Rusk Fresh String Beans Carrot-Raisin Sal. Cantaloupe	Blackberries with Cream Scrambled Eggs * Fried Chicken Mashed Potatoes Green Peas Grapefruit Section Salad, French Dr. Choc. Ice Cream * Sausage Mashed Turnips Glazed Apples Vegetable Salad Chinese Chew	Honeydew Melon Wheat Cakes, Sirup * Crisp Bacon Escalloped Potatoes Broccoli, Hollandaise Sauce Sliced Tomatoes Open Face Blueberry Cobbler * Pork and Noodle Casserole Buttered Beets Frosted Peach Sal. Devil's Food Cake
9	**10**	**11**	**12**	**13**	**14**	**15**	**16**
Orange, Grapefruit Sections Soft Boiled Eggs * Fried Speckled Trout, Tomato Sauce Mashed Potatoes Strawberry Shortcake * Beef Liver Spoonbread Fresh Butter Beans Radish Roses Baked Apple, Lemon Sauce	Royal Anne Cherries Plain Omelet * Country Style Steak Diced Potatoes Buttered Asparagus Celery Hearts Watermelon * Egg Cutlet String Beans Tomato Quarters Apple Betty	Steamed Raisins French Toast, Currant Jelly * Baked Chicken Dressing, Giblet Gravy Candied Carrots Lettuce, Russian Dressing Orange Ice Cream * Crabmeat Salad Potato Chips Gelatin Fruit Sal. Cup Cakes	Bananas Ham with Scrambled Eggs * Beef Stew Potatoes in Jackets Spiced Beet Salad Peaches, Cream * Creamed Chipped Beef on Rusk Buttered Peas Orange Section Sal. Ginger Cake, Hard Sauce	Prune Juice Shirred Eggs * Salmon Loaf Mashed Potatoes Fried Okra Sliced Tomatoes Lemon Sherbet * Cheese Toast Buttered String Beans Olives, Celery Curls Strawberry Shortcake	Orange Juice Scrambled Eggs * Chicken a la King Steamed Rice Julienne Green Beans Radish Roses Honeydew Melon * Baked Ham Potato Salad Pear and Macaroon Salad Chocolate Graham Cracker Pudding	Stewed Figs Bacon Hominy Grits * Swiss Steak Buttered Potatoes Sauted Squash and Onions Tomato and Pepper Salad Pineapple Delight * Braised Tongue Eggplant Creole Cauliflower with French Dressing Fresh Fruit Cup	Grapes Fried Eggs to Order * Broiled Spanish Mackerel Spoonbread Turnip Greens Coleslaw Cantaloupe Scoops * Roast Duck Macaroni and Tomatoes Black-Eyed Peas Sliced Cucumbers Pumpkin Custard
17	**18**	**19**	**20**	**21**	**22**	**23**	**24**
Tomato Juice Eggs a la Goldenrod * Veal Cutlet Mashed Potatoes Broccoli with Hollandaise Sauce Carrot Sticks Bananas * Sausage Hominy Grits Mixed Vegetables Waldorf Salad Cookies	Orange Juice French Toast, Sirup * Roast Beef Parsley Potatoes Buttered Asparagus Tomato Salad Grapenut Ice Cream * Pickle-Pimiento Loaf Egg Salad Sandwich Pickled Beets Apricot Whip	Cranberry Juice Scrambled Eggs * Country Style Pork Chops Potato Puff Sauted Tomatoes and Okra Apple and Celery Salad Butterscotch Pudd. * Meat Loaf, Mushroom Sauce Escalloped Potatoes Baked Acorn Squash Tossed Green Salad Fresh Sliced Peaches	Apple Juice Cheese Toast * Spanish Omelet String Beans Lime Gelatin, Cottage Cheese, Pineapple Salad Ginger Cake, Lemon Sauce * Vegetable Pie Baked Potatoes Buttered Beets Sliced Orange Sal. Caramel Cup Cake	Grapefruit Juice Soft Boiled Eggs * Maryland Chicken Rice with Gravy Fresh Buttered Beans Lettuce, Fr.Dressing Cantaloupe a la Mode * Bacon Grilled Cheese Sandwiches Corn Pudding Sliced Tomatoes Jelly Roll	Tomato Juice Link Sausauge, Fried Apples * Veal Roast Mashed Potatoes Succotash Celery Hearts, Pickles Peach Ice Cream * Creamed Sweet Breads, Bacon String Beans Pear Salad, Cherry Devil's Food Cake	Apricot Nectar Shirred Eggs * Stuffed Tomato with Tuna Salad Cheese Sticks, Sliced Cucumbers Fruit Bars * Cubed Steak Creamed Potatoes Fresh Kale Shredded Carrot, Crushed Pineapple Salad Tokay Grapes	Fresh Apple Juice Soft Boiled Eggs * Crisp Bacon Spanish Rice Chef's Salad Brownies * Lamb Roast, Mint Sauce Escalloped Potatoes English Peas Bing Cherries
25	**26**	**27**	**28**	**29**	**30**	**31**	
Sliced Peaches French Toast, Grape Jelly * Fried Ham Candied Sweet Potatoes Brussels Sprouts Gelatin Fruit Sal. Vanilla Ice Cream * Chicken Salad Potato Chips Tomato Quarters Raspberry Shortcake	Orange Halves Scrambled Eggs * Steamed Frankfurters on Toasted Buns Fried Potatoes and Onions Coleslaw Watermelon * Broiled Calf's Liver Hominy Grits Grilled Tomatoes Sliced Cucumbers Open Faced Apple Pie	Tomato Juice Plain Omelet * Fruit Plate Cottage Cheese, Crushed Pineapple Ball Shredded Wheat Biscuit a la Mixed Fruit Grapefruit Section Salad, Grated Carrots Chocolate Brownies * Buttered Spinach Baked Acorn Squash Lima Beans Egg Salad Cantaloupe	Peach Nectar Shirred Eggs * Chicken, Dumplings Fresh String Beans Tomato Salad Prune Whip, Nuts * Baked Rice, Cheese Curly Kale Perfection Salad Jelly Roll	Grapefruit Juice Bacon * Veal Stew Corn on Cob Bowl Salad Chocolate Ice Cream * Beef Patty Parsley Potatoes Succotash Carrot Sticks Lime Gelatin, Cream	Grapes Beef Hash * Salmon Loaf Parsley Potatoes Spanish Green Beans Relish Plate Brownies * Macaroni Salad Sliced Cheese Sliced Tomatoes Assorted Olives Baked Apple with Mince Meat	Orange Juice Bacon, Eggs * Veal Roll Escalloped Sweet Potatoes,Apples Creamed Celery Honeydew Melon * Vienna Sausage Old Fashioned Spoonbread Black-Eyed Peas Vegetable Salad Cherry Sherbet	

Ready-to-eat or cooked cereals are offered on all breakfast menus.

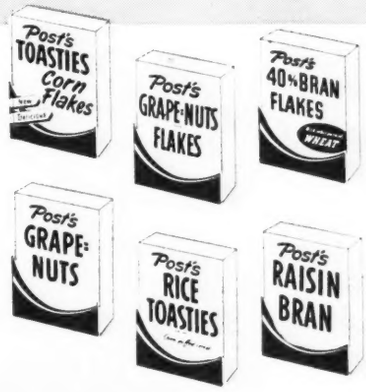
HERE'S HOW POST'S INDIVIDUAL CEREALS HELP HOSPITAL DIETITIANS

Save Money!



No waste! **Fresher!** **Real variety!** **Bonus for you!**

You'll discover many advantages when you serve your patients and employees Post's Individual Cereals. Of all these advantages, the first is THRIFT! Post's 1-oz. packages prevent waste . . . unopened packages can be served again! FRESHNESS is important, too . . . Post's cellophane-wrapped packages assure you freshness and cleanliness. VARIETY is also yours . . . Post's complete breakfast shelf offers a delicious cereal for every taste. BONUS? Valuable premium coupons are packed in all cases of Post's Individual Cereals and with almost all General Foods institution products. If you'd like the Free Premium Catalog, write General Foods Premium Dept., Battle Creek, Mich.



POST'S *Individual* CEREALS

PEOPLE WHO TALK ABOUT GOOD FOOD ...TALK ABOUT GENERAL FOODS!

MAINTENANCE AND OPERATION

A tip from the army—

UNIFIED COMMAND SIMPLIFIES MAINTENANCE

MAX E. GERFEN

Superintendent
Conemaugh Valley Memorial Hospital
Johnstown, Pa.

UPON leaving the army medical administrative corps after about four years of service, I was convinced that many of the systems and procedures of army hospitals could profitably be applied to civilian hospital administration. One of the systems used by the army is described in this article as it relates to the subject of maintenance, supplies and care of grounds.

The size of Conemaugh Valley Memorial Hospital, Johnstown, Pa., afforded the opportunity to put into practice an idea new to me on the control of interior and exterior sanitation, cleanliness and maintenance. I got in touch with our old medical supply officer and asked him to accept the position of director of property and supplies.

THERE MAY BE OTHERS

I do not claim originality in the application of this position to the hospital field. During ten years as a hospital superintendent, I had never heard of such a title, although it is likely that some hospitals might have used this setup.

An outline of the duties and responsibilities of Steno Verrazzani, our director of property and supplies, follows:

1. Responsibility for cleanliness and sanitation of our four buildings.
2. Responsibility for the condition of the grounds.
3. Responsibility for the control, storage and issue of supplies, property and linen.
4. Responsibility for painting and decorating.
5. Responsibility for and control of reporting needed repairs to buildings and equipment.

As would be expected, the director of property and supplies works in close harmony with the chief engineer. All repairs and allied duties are performed by the engineering department; however, the reporting and follow-up of needed repairs are done by the property and supplies director.

The department having been set up, it was necessary to work out the details. We established the position of supervisor of housekeeping to head that branch of the department. We have a chief storekeeper to control supplies and linen. We have a full-time man in control of the grounds, and three full-time painters.

A new stock control system was established whereby minimum quantity levels were posted. A reordering point was put on all items. The keeping of this simple system for our 361 beds and forty-six bassinets requires the services of a girl only three hours a day. Simplicity of systems and controls is the keynote to economy of operation. Prior to the installation of our controlled issue system, everyone and anybody was running to the storeroom at all hours.

Now we have regular controlled issue days on a rotating basis, and all floor supplies are called for at the proper time by a subsidiary worker and not by a nurse or student. The supply room will fill a requisition at any time for emergency purposes.

We were fortunate in that Mr. Verrazzani is an artist as well as a good supply man, and his detailed knowledge of colors and color therapy has assisted us greatly in the application of paint to the various areas in the hospital. The reaction of patients, doctors, visitors and personnel has been gratifying.

The director of property and supplies also investigates new products pertaining to his department. He tests waxes and sealers and new cleaning methods, and he experiments with machines and procedures. This may seem to some a waste of time; however, with new products and materials coming on the market, we feel it has been profitable for us to keep abreast of changes in the maintenance field.

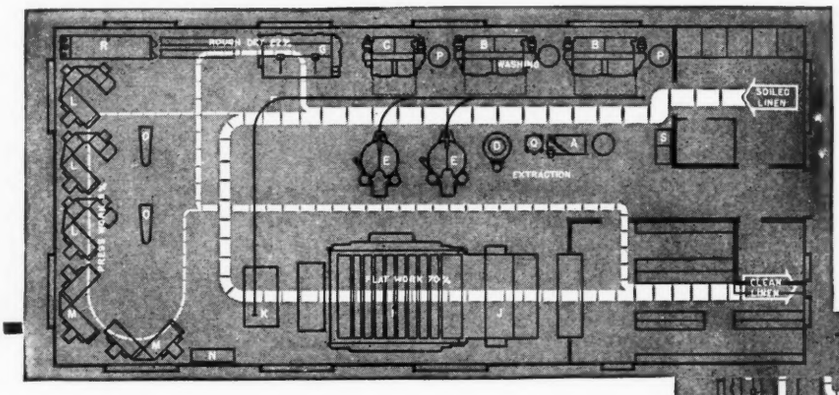
We find, too, that this type of setup affords a better control than would small separate departments. The director of property and supplies is checking on the activities of his division constantly. He can devote as much time as necessary to helping each of his assistants. He has the time to inspect all buildings and rooms daily, thereby ensuring efficient operation of the department.

RESULTS ARE THE PROOF

Now as to the result. First of all, we have reduced our expenditure of salaries by combining the activities of the departments of property and supplies. Employes can be utilized where they are needed in this one department, whereas with little separate entities each employe acquired the feeling of isolation. If for some reason the supply room employes are not kept busy they can fill in elsewhere in the department. However, this situation does not occur daily. By the use of labor saving machines and by careful selection of personnel we have achieved greater efficiency and economy. We have found in some cases that one man can do more work and better work than two women can. I point out these facts merely to demonstrate that we take advantage of every opportunity to improve this department.

We can truthfully say that our hospital is clean and sanitary. There is a distinct saving of the administrator's time when problems arise in this department. I can relay instructions and policies through one person for all the activities discussed herein. Hospitals that now operate separate small departments may find our experiment applicable and may achieve as gratifying results as we have.

LAYOUTS FOR *LOWER* LAUNDRY COSTS

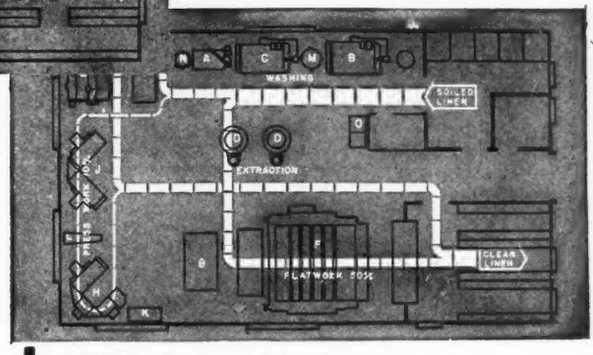


400-Bed General Hospital
(Laundry area: 40'x90')

Large volume classifications move the shortest possible distance in this highly productive Hoffman laundry layout.

500-Bed Neuro Psychiatric
(Laundry area: 37'x65')

A Hoffman plan for correct flatwork, rough dry and press work capacities as indicated by preliminary study.



A *Specialized* SERVICE PROVIDED IN YOUR HOFFMAN SURVEY

EXPERTLY PLANNED FOR THE EXACT NEEDS OF EVERY SIZE AND TYPE OF INSTITUTION

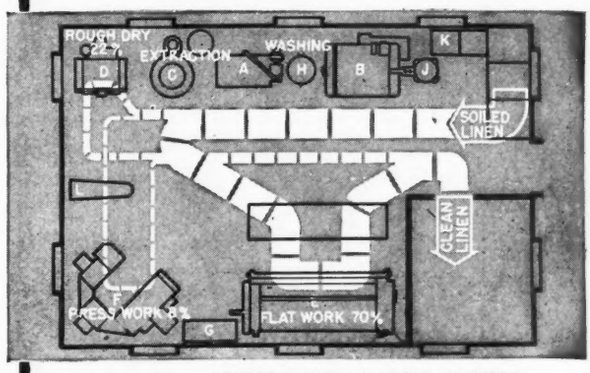
Be sure of maximum economy in your new or modernized laundry with a HOFFMAN Survey. This valuable service has been proved by hundreds of institutional laundry installations planned by Hoffman layout engineers.

With their extensive experience these Hoffman specialists can help you to save floor space, save time and labor, save linen, and save fuel and supplies. Their practical advice covers every essential of successful laundry operation. Increased production, without increase in floor space, is very often made possible by their comprehensive analysis and plans.

If you are now considering modernization of your present laundry—or planning a completely new layout, a call to Hoffman will bring this survey service. There is no obligation.

50-Bed General Hospital
(Laundry area: 22½'x33½')

Minimum weight handling in a functional arrangement for a small floor space.



WRITE FOR YOUR COPY OF THIS PREVIEW BOOKLET

FREE—NO OBLIGATION

A new 16-page booklet that describes Hoffman institutional laundry equipment and services.

Three full pages of layout information and plans. A handy, helpful reference.

U. S. HOFFMAN MACHINERY CORPORATION

107 Fourth Ave., New York 3, N.Y.

INSTITUTIONAL LAUNDRY DIVISION • BRANCHES IN ALL PRINCIPAL CITIES

HOUSEKEEPING

Conducted by Alta M. La Belle and Jane Barton

When It's Time to Refinish

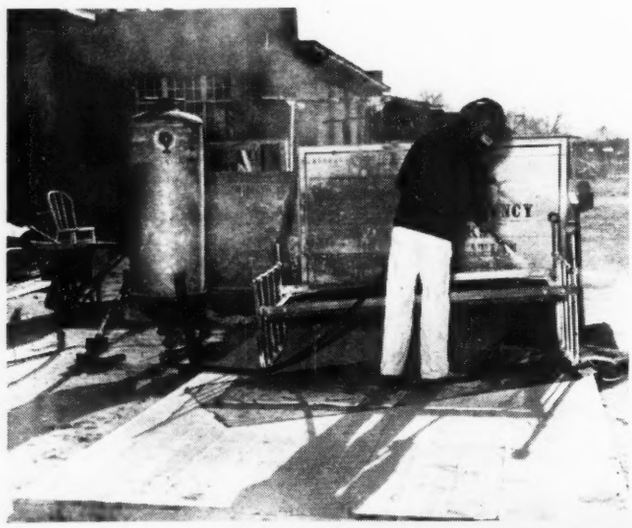
RALPH C. TAYLOR

Pueblo, Colo.

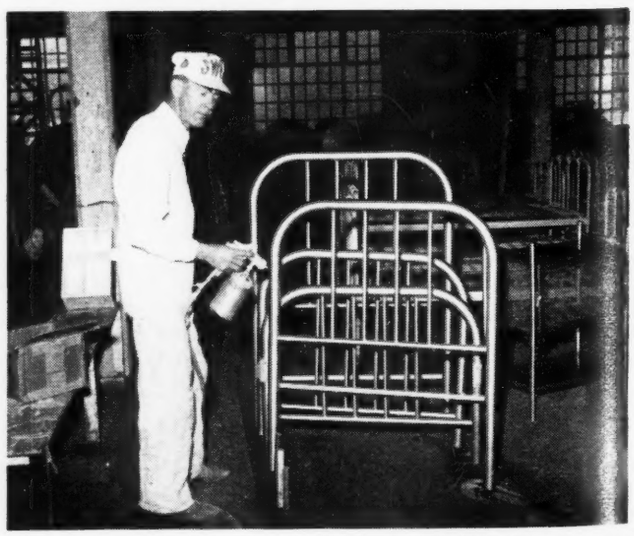
HOSPITALS, hotels and other institutions in which bed maintenance is a constant problem can profit from shortcuts and improved methods developed at Colorado State Hospital in Pueblo.

The hospital paint shop developed a new fast drying prime coat and satin aluminum finish that is much more satisfactory, attractive and durable than is the old white enamel finish. There is less chipping. However, with 4700 beds in use, there always are beds that need refinishing.

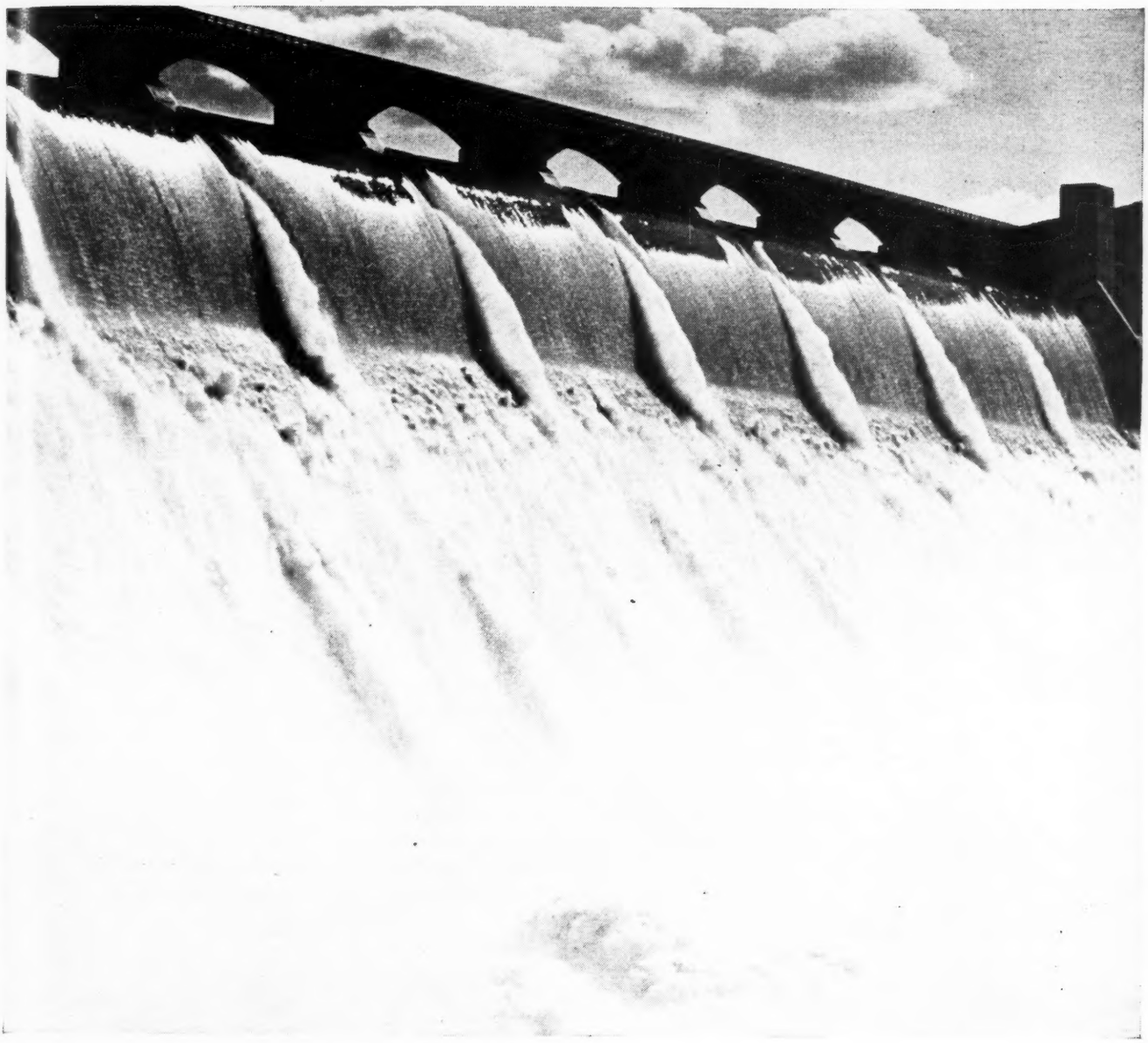
The old hand method of paint removal took too much time. Carl Holmgren, in charge of the machine shop, built a sandblasting machine that is designed especially for removing paint from beds. A job which required hours by hand and which still lacked smoothness now can be turned out in thirty minutes. The new finish is then quickly applied with a spray gun.



Left: When there are 400 beds that need refinishing, the job is tremendous if it must be done by hand. However, with the sandblasting method employed in this picture, it is done relatively easy.



Right: Sandblast gives a smooth finish and the new prime coat and satin aluminum finish go on quickly and attractively with a spray gun. Pegs from planking hold the bed frames.



WASHING MORE POWER TO YOU... WITH NEW WYANDOTTE SKORTEX

Wyandotte Skortex sets a new mark in *greater washing power.*

The result of months of laboratory and field tests, this new-type compound combines the properties of (1) a superior wetting agent and detergent and (2) a "built-in" material which improves whiteness retention and promotes detergent action.

Skortex is used to replace soap, either partially or entirely, on all classifications of white and colored work — including linen supply. It is gentle to the most delicate fabrics and colors but remarkably effective for heavily soiled work when used in conjunction with a Wyandotte builder.

Skortex works effectively in hard as well as soft water. Because it removes lime-soap from fabrics, it brightens white and colored work. It cleans up wheels — removing scale and other impurities — and helps keep them clean.

You'll find that Wyandotte Skortex will help you turn out quality work, at a worth-while saving in costs.

Your Wyandotte Representative is ready to demonstrate the many benefits of this new, specialized Wyandotte Product, at your convenience.

SEE OUR CATALOG IN THE HOSPITAL PURCHASING FILE — HPF

WYANDOTTE CHEMICALS CORPORATION
WYANDOTTE, MICHIGAN SERVICE REPRESENTATIVES IN 88 CITIES

Wyandotte REG. U. S. PAT. OFF.

NEWS DIGEST

Gorgas Heads New Upper Midwest Organization . . . McNamara, Kelly Resign from Cleveland Plan . . . Father Barrett Named Catholic President-Elect . . . Topeka Leaders Plan Expanded Health Program

Nellie Gorgas Elected President of Upper Midwest Hospital Conference

MINNEAPOLIS.—The first annual convention of the newly organized Upper Midwest Hospital Conference brought 1700 hospital people together here early in June. In attendance and enthusiasm, the meeting exceeded the most ambitious hopes of the Upper Midwest officers, it was reported.

Nellie Gorgas of St. Barnabas Hospital, Minneapolis, is the president of the new association. Donald Cox of Winnipeg is vice president and Glen Taylor of the University of Minnesota, secretary and treasurer.

YOUNGDAHL OPENS MEETING

The meeting was opened by Gov. Luther W. Youngdahl of Minnesota who pleaded the cause of enlightened understanding and care of the mentally ill and stated his conviction that economical operation of state governments demanded adequate and proper public health nursing and hospital services.

Russell Nye, administrator of the Northwestern Hospital, Minneapolis, described a study of nursing service that has been conducted at Northwestern Hospital for the purpose of effecting a reassignment of nursing duties to registered nurses, practical nurses, nurse's aides, clerks and orderlies in accordance with the most economical arrangement consistent with the training and experience of these various units. Mr. Nye also described the effect of changing the starting time for the daily nursing service from 7 to 8 a.m., the methods used in carrying out the new nursing program with a higher percentage of practical nurses, nurse's aides and clerical personnel and the introduction of "piped in" music in various areas of the hospital.

James Stephan, associate professor of hospital administration at the University of Minnesota, told the results of a survey of professional opinion among architects on the effectiveness of "Appendix A," the architectural regulations governing hospital construction under Public Law 725. While individual criticisms emerged in connection with various features and details of the regulations, Mr. Stephan reported, the prevailing opinion among architects is that the regulations will greatly aid the cause of better and more economical hospitals.

Meeting concurrently with the Upper Midwest Conference, the Minnesota Hospital Association named Sister Anna Bergland, superintendent, Lutheran Deaconess Hospital of Minneapolis, its president. Other Minnesota officers elected were John M. Axelson, Virginia, president-elect; Raymond Swanson, Minneapolis, first vice president; Helen Eyk, Montevideo, second vice president, and Richard Fox, Duluth, treasurer.

McNamara, Kelly Leave Cleveland Blue Cross

CLEVELAND.—John A. McNamara and Michael Kelly have resigned as directors of the Cleveland Hospital Service Association, it was announced here in June. According to newspaper reports, McNamara and Kelly said they were resigning at the expiration of their present contract with the association June 15, 1949, but association trustees accepted the resignation "effective at once."

McNamara and Kelly will leave Cleveland, it was reported, to join a new organization in the East. They had been connected with Cleveland Blue Cross since it was organized in 1934.

Cleveland papers reported a dispute over the amount of salaries due McNamara and Kelly under their contracts, though board members praised their work.

C.H.A. Elects Barrett

The Reverend John W. Barrett was named president-elect of the Catholic Hospital Association at the annual convention held in Cleveland June 7 to 10. Father Barrett is diocesan director of Catholic hospitals in Chicago. A report of the meeting will appear in the July issue of The MODERN HOSPITAL.

Establishes Course in Pastoral Training

WINSTON-SALEM, N.C.—North Carolina Baptist Hospital here has established the first course in this section of the country to bear the title of pastoral clinical training. Conducted by the hospital's department of religion, the course is given in conjunction with the Southern Baptist Theological Seminary and is designed to equip pastors to help the ill in solving their problems, particularly psychological problems, a hospital announcement says. Seven students have completed theological internships at the hospital under the direction of Richard K. Young, hospital chaplain.

The pastoral program consisted of ten weeks of classes and clinical visits for students planning to enter the ministry or other religious work.

A second course in clinical pastoral training, for ministers already in the field, is now under way. A group of Negro ministers in Winston-Salem, realizing that the same need of understanding the problems of the sick exists among members of their congregations, asked Mr. Young to conduct a similar course for them. Five Negro ministers completed their course recently.

NEWS . . .

Topeka Leaders Hear Kyser Outline Need for Better Health Program

By LILYAN C. ZINDELL

Lilyan C. Zindell

TOPEKA, KAN. —Kay Kyser again proved his earnestness and sincerity of purpose when he outlined the need for better health programs here recently. Less than three hours after Kyser delivered a stimulating address to civic, health and hospital leaders revealing health needs in the Topeka area, a citizens' health committee was organized and immediate plans were laid for solving such problems as proper added sewage disposal, increased recreational facilities, and unified efforts for providing the necessary hospital facilities to meet a minimal standard of at least four beds for each 1000 population, with added facilities and equipment for the highest type of clinical teaching program for student nurses.

Praises Organization

The Topeka-Shawnee County Health organization was praised by Kyser as an outstanding and progressive step toward improved health programs. He also commended the Kansas Public Health Service on its newly organized premature infant program. "However," Kyser said, "neither this nor any other program can be carried out successfully without adequate facilities and properly trained personnel, both of which cost money which must be forthcoming if our present voluntary systems are to survive." He emphasized that "health must receive first consideration from city planners, county commissioners, school authorities and parent-teacher associations," in addition to local health agencies and hospital and medical authorities.

The importance to industry of supporting good health and hospital programs was emphasized and the costliness of absenteeism was pointed out. "Good health is good business," Kyser declared.

"Among services urgently needed in general hospitals are facilities for the mentally ill and for saving the lives of premature infants born outside the hospital as well as in the hospital, and improved facilities for good clinical instruction of student nurses and interns."

Summing up the health problem with a recommendation for its solution, Kyser's formula is simple: "Make your product (service) good and keep the public informed." He pointed out that if people are kept properly informed of the community's needs they will respond with all the help and assistance any situation requires to expand health facilities for themselves and their families.

The Citizens' Health Committee has requested that fact sheets be presented from all health and hospital agencies. The information to be given includes present facilities, a list of needs and problems, and suggestions for solving those problems. When the information requested is received and tabulated, the committee will be in position to inform the community of its health assets, as well as its needs, and will be able to go definitely about the task of making corrections and advocating certain definite programs for improving and expanding facilities.

The Topeka Hospital Council extended the initial invitation to Kyser to come to Topeka and present his inspirational message. The Topeka Chamber of Commerce enthusiastically accepted an invitation to join the Hospital Council in this endeavor, and Kansas Blue Cross also aided in the project.

Guests at the two Topeka meetings, a luncheon for civic, health, business and hospital leaders, and an evening meeting to which the general public was invited included Graham Davis, president of the American Hospital Association; L. W. Austin, past president of the Mid-West Hospital Association; Paul Fesler, trustee of the Mid-West Hospital Association, and William Simmons, Chicago hospital consultant. The Kansas Hospital Association was represented by Mrs. DeLore Rodeen, president-elect.

Seminar in Navy Research

WASHINGTON, D.C.—A seminar in scientific naval research began here June 9. Medicine, applied physics, atomic energy, mathematics and psychological studies are included among the subjects of the seminar which is being held for the benefit of 100 reservist officers. The course provides an opportunity to observe the operations of the Office of Naval Research and to visit the Naval Medical Research Institute, the Naval Ordnance Laboratory, the David Taylor Model Basin and various other scientific research activities.

Senate Passes Revised Science Foundation Bill

WASHINGTON, D.C.—The Senate has passed the National Science Foundation bill, S.2385, introduced by Senators Smith, Cordon, Revercomb, Saltonstall, Thomas of Utah, Kilgore, Magnuson and Fulbright. The bill has now been referred to the House committee on interstate and foreign commerce. The same senators sponsored S.526 passed by both Houses in the first session of the 80th Congress and vetoed by President Truman.

According to Senator Smith every effort has been made to rewrite the present bill in order to meet most of the objections which the President raised to the original measure. The most far-reaching change, he said, made in the pending bill over S.526 is concerned with the office of the director. It provides that the director shall be appointed by the President by and with the advice and consent of the Senate. Under S.526 the director was appointed by the foundation itself.

The present bill has also eliminated the provision for an executive committee. It empowers the foundation, however, to appoint such committees and special commissions as it deems necessary.

In the pending bill, no provision has been made for a division of national defense. It contains no provision for the creation of an interdepartmental committee on science. It does not specifically establish any named special commissions but it does give the foundation authority to establish such special commissions as it deems necessary. This authority permits the foundation to make its own provisions for meeting pressing medical and scientific problems as they arise.

Otherwise, the present bill closely parallels the provisions of S.526.

Oleo Bill Headed for Passage

WASHINGTON, D.C. — The Senate finance committee on May 27 unanimously approved the bill to repeal the oleomargarine tax. An amendment to the bill provided that no person shall serve colored oleomargarine at a public eating place unless each serving was labeled to identify it as oleomargarine, and a notice that the eating place was serving oleomargarine would have to be displayed.

The bill's fate will now be decided on the Senate floor unless the amendment makes it necessary to return the bill to the House where it might go back to the House rules committee or the agriculture committee.

NEWS . . .

Hospital Reports on Care of Columbia River Flood Victims

PORTLAND, ORE.—During the first week after the flood disaster in this area last month the following report to MODERN HOSPITAL was made by a hospital administrator in Portland:

"While for days warnings of the flooded condition on the Columbia had been broadcast, the suddenness of the break in the dike, flooding the Vanport area, took all by surprise and created an unforeseen emergency. Vanport was a city of 17,000 inhabitants, occupying barrack-like facilities built during the war to house ship workers. At this moment it is unknown how many people were trapped in these houses which floated off their foundations, crashed into each other and disintegrated into a pile of flotsam.

"The hospitals were alerted through the secretary of the state hospital association. On hearing radio broadcasts of the catastrophe, hospital employes automatically reported for duty. These included nurses, doctors, dietitians, orderlies and clerical help. During the first few hours following the emergency, the hospitals received the following types of cases: (1) shock, (2) fractures, (3) lacerations.

"Emanuel Hospital, which is located nearest the scene of the catastrophe, received most all of the cases, a small trickle going to the other hospitals.

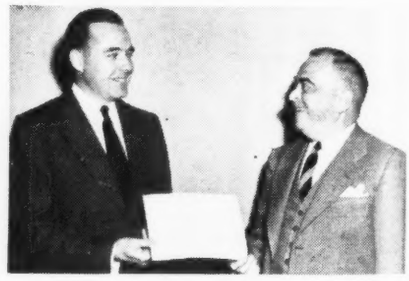
"Experiences gained in other disasters were applied to handling the victims, who were nearly all outpatients. A system of classifying and identifying the casualties was inaugurated. Most of the victims lost all their possessions except the clothes they were wearing. Shelter had to be found through the Red Cross for these victims after being treated. Also, the problem of locating their missing relatives was handled by the hospital chaplains and social workers. Hospitals were called on to furnish supplies. Diapers and nursing bottles were sent to quarters housing children. Diabetic patients had to be furnished with insulin and syringes. Mothers lost their layettes for newborns, which are being furnished.

"Many hospital employes lived in this area. So far, none is known to have perished. Many have lost all their belongings. The hospitals have provided temporary quarters for them in classrooms and elsewhere. Fellow employes and the hospitals are assisting them in obtaining new clothing.

"There are more than 40,000 displaced persons in the Columbia River Valley (including Vanport) from Portland to the sea. This situation will aggravate the need of hospitalization among these refugees. The hospitals in the area, in cooperation with the Red Cross, will take cases on a rotation basis. The greater problem at the present moment is that of clothing and shelter for the victims. Hospital personnel has volunteered in caring for these victims at the Red Cross centers, dietitians have helped establish and supervise formulas for babies, and nurses are doing volunteer work. As they always do, hospitals have played a major part in this disaster."

City Hospital Joins Philadelphia Council

PHILADELPHIA.—Philadelphia General Hospital, a municipal institution, was admitted to membership in the Hospital Council of Philadelphia at the second annual meeting of the council here last month. The city hospital is the fifty-sixth institution to join the citywide council and the first member hospital operated by a government agency, C. Rufus Rorem, council director, said. "Membership of the city hospital emphasizes the interdependence of all institutions in the care of the sick," Mr. Rorem stated. "Voluntary contributors and taxpayers are essentially the same groups of people. Their support of hospital care should be coordinated in the interest of the welfare of the people in the Philadelphia area."



Mayor Bernard Samuel and Erwin A. Stuebner hold certificate presented to Philadelphia General Hospital by the council.

J. Hamilton Cheston was elected council chairman for the coming year. Other officers named include T. Truxtun Hare, Bryn Mawr Hospital, vice chairman; Thomas M. Farr, Cooper Hospital, Camden, N.J., secretary; William L. Dav[illegible], University of Pennsylvania Hospital[illegible], treasurer.

Now! GREATER CAPACITY OF FROZEN FOODS IN AMAZING LOW COST Amana FREEZER!

Food Service Leaders Say:

Amana Freezer . . .

. . . "Takes Guesswork Out of Food Calculations."

. . . "Ends Food Storage Spoilage. Saves Preparation Time."

. . . "Ends Variety Starved Menus."

Amana Upright Uses Less Floor Space! . . . Quick Freezes Foods, Too!

- Only 48" wide floor space needed for 30 cubic foot capacity Amana Freezer. All foods are easy to reach and contact freezer plate shelves give you your own private quick freezing plant if you wish to quick freeze your own foods!
- The new Amana Freezer is extra easy-to-clean — non-rusting, non-chipping, non-corrosive — because it's all satiny stainless steel — inside and outside. Amana's a real joy for sanitation and perfect food preservation. Get the AMANA facts today!

AMANA SOCIETY, REFRIGERATION DIVISION **Amana, Iowa**

Pioneer specialists in low temperature refrigeration with a century-old tradition of fine American craftsmanship.

NOW!

PROVE THESE FACTS IN YOUR OWN FOOD OPERATION without obligation

Write or wire today for AMANA'S

30 Day Test Offer Plan!

- Install Amana Freezer! If you are not fully satisfied after 30 days we will refund all cash paid and remove Amana at no cost to you. Prove to yourself the tremendous savings Amana Freezer will bring to your food operation. Act today!

Mail Coupon Now!

Refrigeration Division
Amana Society, Amana, Iowa

Send full details and information of Amana Freezer 30 day test offer plan.

Name .....

Firm .....

Address .....

City ..... State .....

NEWS . . .

Thomas Introduces Bill Providing for Medical Education

By EVA ADAMS CROSS

WASHINGTON, D.C.—Senator Thomas of Utah's medical education bill introduced recently would cut down the doctor, nurse, dentist and other health personnel shortage by making substantial grants to schools of medicine, nursing, dentistry and public health. It proposes financial assistance in the construction of new schools to give medical and related education, and the expansion of existing schools of the sort. It would give more qualified individuals a chance to get such training and it would establish scholarships to equalize the opportunities for education in medical and public health fields.

For grants to schools of medicine, there would be authorized $18,000,000 for the fiscal year ending June 30, 1949; $20,000,000 for the fiscal year ending June 30, 1950, and such sums as may be necessary for each fiscal year thereafter.

For grants to schools of nursing (both graduate and undergraduate), the bill proposes an appropriation of $15,000,000 for the fiscal year 1949; $18,000,000 for the following fiscal year, and such sums as may be necessary for each fiscal year thereafter.

For grants to schools of dentistry, the bill calls for an appropriation of $6,000,000 for the first fiscal year; $8,000,000 for the second, and such sums as may be deemed necessary for each fiscal year thereafter.

For grants to postgraduate schools of public health, there would be appropriated $1,500,000 for the first fiscal year; $2,000,000 for the second, and such sums as may be necessary for each fiscal year thereafter.

The proposed legislation would also authorize to be appropriated from time to time such sums as may be necessary to enable the surgeon general to make grants to assist in the construction of school buildings and other school facilities. Such grants would be made in order of the estimated importance or value of the construction in alleviating the shortage of personnel in the medical, nursing, dental and public health fields. No such grant would be in excess of 50 per cent of the cost of the construction.

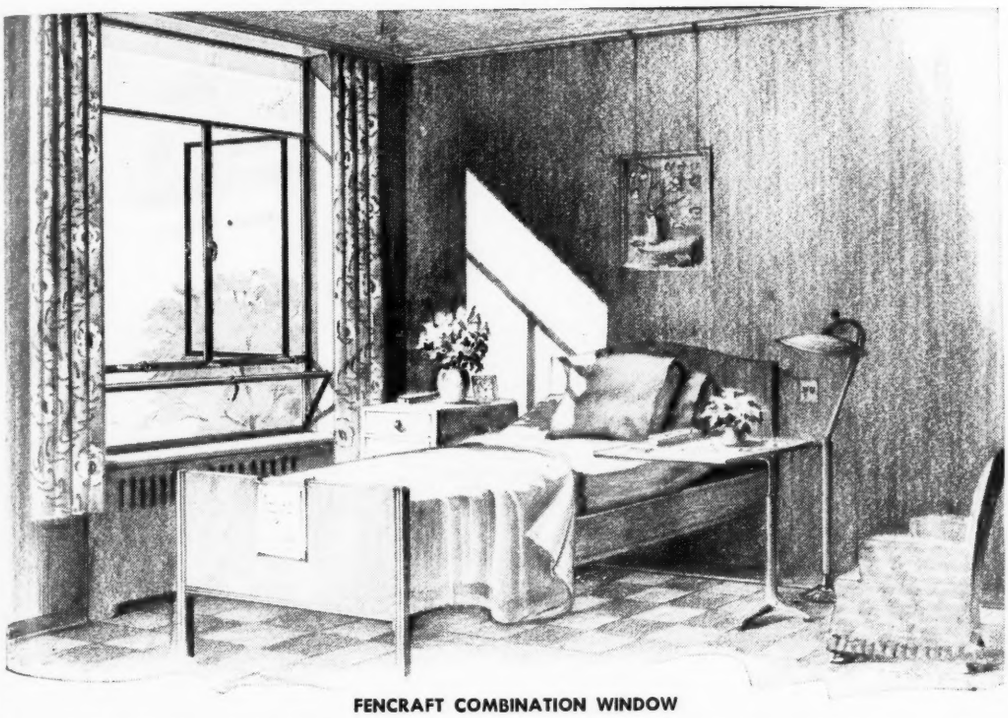
No payments would be made to any school unless it admits students without discrimination on the basis of race, creed, color or national origin, except in the case of schools located within a state where separate facilities are required by law to be maintained for separate racial groups.

In order further to increase the number of adequately trained persons, there would be appropriated for each fiscal year a sufficient sum to enable the surgeon general to make payments to the states to cover the cost of state scholarships awarded to individuals for such training. The total number of such scholarships would not exceed 10 per cent of the students enrolled for the standard course given by the schools providing training in such field.

In addition, the bill would make provision for national medical scholarships to increase the number of physicians available for the practice of their profession in governmental health activities or in areas where there is a shortage of physicians. Not more than 600 such scholarships would be awarded annually.

Senator Thomas stipulates there would be no federal interference in the internal affairs of schools aided by the provisions of his bill.

How to pay less for "Some of the best medicine in the world"



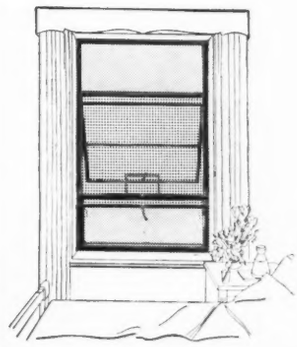
FENCRAFT COMBINATION WINDOW

Lots of daylight and fresh air . . . you know their benefits in convalescence. You can bring both into your hospital more *economically* with Fenestra* Fencraft Steel Windows.

Why economically? Because Fenestra has designed these windows to keep window costs down without sacrificing quality, beauty or efficiency. Standardization of types and sizes has resulted in lower first cost and in simplified installation.

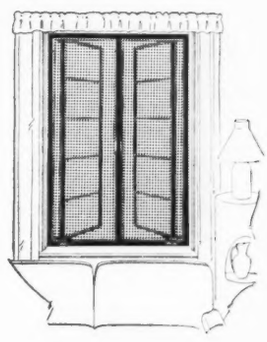
What a job these windows do! Note how the Fencraft Combination Window, above, floods the room with daylight . . . how its open-in vent brings in and controls fresh air, deflecting drafts upward. Rain is safely shed to the outside. Note the vertical swing leaves that catch breezes from every direction. Up to 100% window opening may be had when desired.

All three windows in the newest Fenestra family—Fencraft Combination, Casement and Projected—provide many benefits important for hospitals. Permanently-easy operation . . . more daylight . . . better ventilation . . . safer cleaning . . . superior screening . . . lasting weather-tightness . . . firesafety . . . low maintenance . . . beauty inside and out. And don't forget their economy.



FENCRAFT PROJECTED WINDOW

—open-out vent acts as weather-protecting canopy over opening. Open-in vent deflects air upward, sheds water outside. Movable air conditioning unit easily attached.



FENCRAFT CASEMENT WINDOW

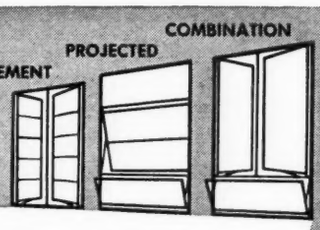
—safe outside washing—from inside. Easy to operate. Interchangeable inside screens, protected from outside dirt. Ideal for nurses' homes and staff houses.

You can be confident of the high quality of Fencraft Windows, for they are made by skilled craftsmen in the shops of America's oldest and largest steel window manufacturer. For full information, including types and sizes, mail the coupon.

*®

Fenestra

CASEMENT PROJECTED COMBINATION



FENCRAFT INTERMEDIATE STEEL WINDOWS

Detroit Steel Products Company,
Dept. MH-6,
2258 East Grand Blvd.,
Detroit 11, Michigan

Please send me data on types and sizes of the new Fencraft family of Fenestra Windows.

Name_____

Company_____

Address_____

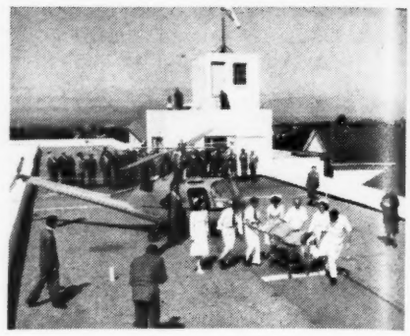
NEWS . . .

Herrick Memorial Opens First "Heliport" for Sky Ambulances

BERKELEY, Calif.—Opening of the first hospital roof "heliport" designed to receive emergency patients from the air took place here last month at the Herrick Memorial Hospital when the first helicopter ambulance landing was made on the specially constructed roof of the hospital.

The emergency facility has been designed with elevators running directly from the heliport so that emergency patients can be wheeled directly from the roof to the operating room, Alfred E. Maffly, hospital administrator, said.

The helicopter demonstration was part of the dedication ceremonies for the new million dollar hospital building honoring LeRoy Francis Herrick, who founded the hospital in 1904. The heliport on the roof of the new hospital will greatly expand the effective range of the emergency hospital facilities, Mr. Maffly explained.



Herrick Memorial Hospital's new heliport.

Hereafter, patients injured at great distances from the hospital can be brought quickly to the hospital by sky ambulance.

Three Groups Confer on Health Problems

WASHINGTON, D.C.—The week of May 17-21 saw conferences here on mental, dental and other aspects of health. The American Psychiatric Association held its 104th annual meeting with more than 2500 psychiatrists and members of allied professions attending. Dr. George S. Stevenson, medical director of the National Committee of Mental Hygiene, was elected president of the association for 1949-50. He succeeded Dr. William C. Menninger.

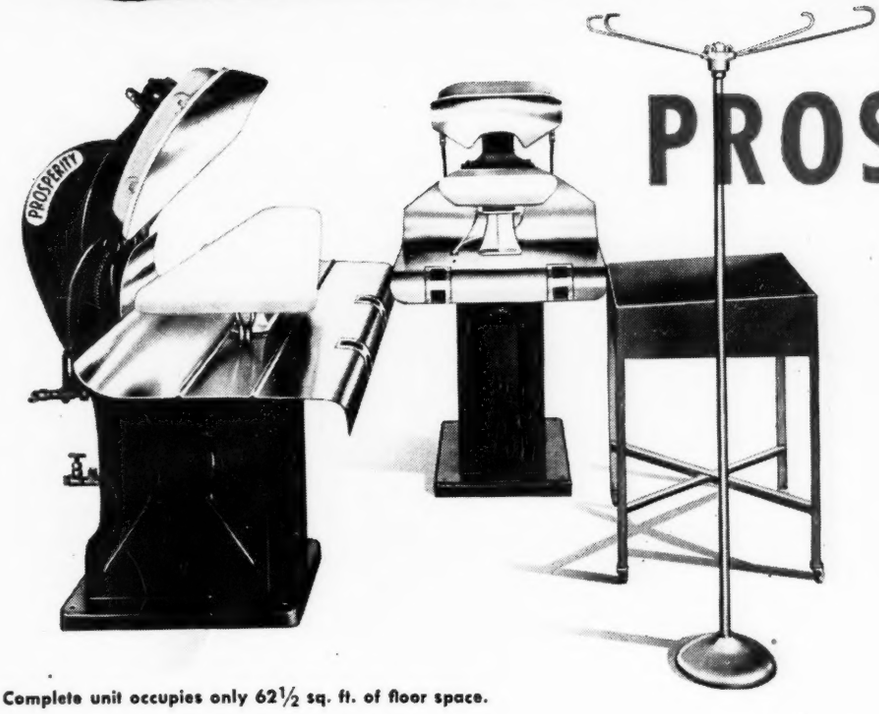
In a panel discussion sponsored by the Washington section of the International Association for Dental Research, dentists and physicians were urged to make a closer study of the nose and throat in cancer research.

A six-day postgraduate course in internal medicine at Gallinger Hospital was sponsored by the American College of Physicians for 100 specialists. The program, directed by Dr. Wallace M. Yater, opened with a discussion of infectious diseases and antibiotics. Subjects under study ranged from the common cold to the diagnosis and treatment of headaches.

Plans Auxiliary Conference

CHICAGO.—Plans for the American Hospital Association conference of women's hospital auxiliaries in Atlantic City concurrent with the fiftieth anniversary convention were formulated at a meeting of the planning committee last month, an association announcement said. The program includes speeches on women's auxiliary groups ranging from services, finances, the place of the group in a total hospital program, and public relations, to organization on local, city, province, state and national levels.

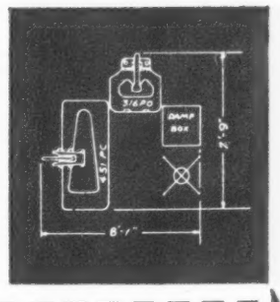
Completely Machine Finishes
All Standard Nurses' Uniforms



Complete unit occupies only 62½ sq. ft. of floor space.

PROSPERITY
One-Girl
NURSES' UNIFORM UNIT

DESIGNED especially for the popular belted-type of uniform, this one-girl, two-press unit will turn out a higher volume of smartly pressed work . . . completely machine-finishing the great bulk of both belted and unbelted types. Only a small amount of hand touch-up is required on the occasional uniform with intricate style details.



ALL THESE FEATURES

- **MODEL 451 PC press has tapered buck which fits into gathered waists of belted uniforms. Buck is of correct curvature for completely finishing full skirts.**
- **This PC buck is long enough to finish cuffs and skirt at the same time.**
- **MODEL 316 PO press buck is specially shaped to finish sleeves from cuff to shoulder.**
- **This PO press shapes and finishes shoulders smartly . . . and finishes waists from belt up.**

THE PROSPERITY COMPANY, Inc.

AUTOMATIC PRECISION PRODUCTION TOOLS FOR LAUNDRY AND DRY CLEANING PLANTS.

Trade mark PROSPERITY Reg. U. S. Pat. Off.

Main Office and Factory, Syracuse 1, N. Y.
Sales, Service and Parts in All Principal Cities

Direct Sales Made by Wholly-Owned Subsidiary THE PROSPERITY COMPANY, Inc. (a Delaware Corporation)

The Prosperity Company, Inc.
2224 Erie Blvd., East, Syracuse 1, N. Y.

☐ Please send me complete details on your one-girl Nurses' Uniform Unit.
☐ Have your Representative call.

Hospital .....
Address .....
..... CITY ZONE STATE
My name .....

NEWS . . .

Hospital Day Programs Acquaint Public with Need for Support

NEW YORK.—Hospitals throughout the country observed National Hospital Day last month with celebrations which had a serious purpose—acquainting hospital communities with the personnel and financial problems of hospitals today and the public understanding and support necessary to their solution.

The biggest meeting was held in New York City where Hospital Day was the occasion for recognition of the hospital careers campaign planned by the American Hospital Association and the Advertising Council. At the New York meeting awards were made to Roy Larson, president of the United Hospital Fund, and Charles G. Mortimer Jr., chairman of the Advertising Council, for their work on behalf of hospitals. Also featured at the meeting was a talk by Helen Hayes who gave her services in the preparation of a moving picture appeal which is part of the hospitals' nurses' recruitment program.

Other Hospital Day observances included a day of meetings, radio broadcasts and public proclamations in Baltimore. This observance included a radio broadcast of the graduation exercises at West Baltimore General Hospital School of Nursing and a broadcast of a round table discussion on nursing arranged by the Maryland State Nurses' Association.

In Boston a committee for the study of hospital costs and finances presented a radio discussion on the question "Are we facing a breakdown of our voluntary hospital service?" Participants in the program included Frank E. Wing, chairman; Dr. Norbert A. Wilhelm, Ann Houck, Dr. Albert G. Engelbach and Dr. Gerald F. Houser.

In a Hospital Day release, the Illinois Hospital Association stressed the number of patients cared for in hospital facilities throughout the state, and the additional facilities now planned or under construction in the state's hospital program. The release also emphasized the need for student nurse candidates as the "No. 1 project for all hospitals and for the public in general."

A successful small community observance of the occasion was presented by the Community Hospital at Covina, Calif., where the newly remodeled and refurnished hospital lobby was formally opened. Other features of the Covina observance included unveiling of a portrait of the hospital's founder; hospital tours conducted by girl scouts; displays of hospital equipment, including a public demonstration of a resuscitation unit donated to the hospital by the Rotary Club.

In Freeport, Ill., the women's board of the Deaconess Hospital made arrangements with churches throughout the community to present hospital speakers during their services on the Sunday preceding Hospital Day. Talks were made by members of the hospital board of trustees and women's board in twenty churches. "The program was accepted in a splendid way and did a lot to make people aware of our hospital and the critical situation we are facing because of inflation," Leonard W. Hamblin, administrator, reported.

Hospitals in Washington, D.C., used "Know Your Hospital Month" beginning with National Hospital Day and ending June 12 as a means of acquainting the public with why they are operating in the red. W. R. Castle, president of the hospital council said the council made public financial figures on 1947 hospital operations in Washington.

NEWS . . .

Report 1000 Vacancies in Army Nurse Corps

WASHINGTON, D.C.—Approximately 1000 vacancies presently exist in the army nurse corps, according to a recent report. As of April 1, the corps was composed of 4796 nurses actually on duty caring for patients in 167 fixed installations in the zone of the interior and in foreign theaters.

In order to meet nursing needs, there were, as of April 1, 242 civilian nurses employed in army general hospitals. Appointment of civilian nurses under this quota is on a temporary basis until such time as sufficient regular army and reserve nurses are available as replacements.

The reserve corps program for nurses is intended to provide a reservoir of qualified nurses needed over and above the minimum strength authorized by the regular army nurse corps. In case of a national emergency, such nurses will be oriented in the military service and made available for active duty.

The following courses have been established for army nurses: psychiatric nursing for six months; anesthesiology, thirteen months; hospital and nursing administration, four months; operating room technic and management, six months; basic military course, eight weeks, and nursing education at a recognized university for a period of one academic year.

To be eligible for all courses conducted by the army, an army nurse must be in one of the following categories: (A) a member of the regular army; (B) member of the officers' reserve corps who has signed a statement of intention of remaining on extended active duty for a period of two years after completion of the course concerned.

An average of 100 nurses is enrolled at all times in courses ranging from four to thirteen months in length.

G. W. Hospital Offers Increased Service to Medically Indigent

WASHINGTON, D.C.—When all clinics are operating at capacity at the new George Washington University Hospital, the staff will be able to care for some 1200 to 1300 patients a month compared to 450 monthly in the old building, Dean Walter A. Bloedorn, medical director of the hospital, said here June 5.

Additional space and equipment have made it possible to expand greatly the program of the outpatient department. Approximately 90 Washington physicians are donating their time for the operation of these services under the direction of Dr. Clarence Hartman of the hospital staff.

Nine new services, including a clinic in plastic surgery, are being made available to the sick who cannot afford to receive treatment from their own physicians.

V.A. Radio-Isotope Program

WASHINGTON, D.C.—Doctors working with the Veterans Administration's radio-isotope research program report encouraging progress, especially in new methods of diagnosis, according to a V.A. report. Leukemia patients are now being treated with radio-phosphorus in most of the seven V.A. hospitals having radio-isotope units, and radio-iodine (another atomic pile by-product) is being employed to treat some thyroid diseases. Radio-isotope units are also making studies on metabolic diseases and on circulation of the blood.

now.. AVAILABLE TO HOSPITALS EVERYWHERE

TRADE **Vaseline** MARK

Petrolatum Gauze Dressing

(Type I Absorbent Gauze U.S.P. 3" x 36"
Impregnated with "Vaseline" White Petroleum Jelly U.S.P.)

Sterile

BAYBANK PHARMACEUTICALS, INC.
NEW YORK 4, N. Y. • MADE IN U. S. A.
Division of Chesebrough Mfg. Co. Cons'd.

SEE INSTRUCTIONS ON REVERSE SIDE

for

Local Application to Burns and Wounds

Developed exclusively for our Armed Forces during World War II, these new Sterile Petrolatum Gauze Dressings are now available to civilian hospitals in the same individual, compact, convenient, ready-to-use *sterile* packages—for first-aid *and* definitive local therapy of burns . . . as a bland dressing and protective covering for numerous purposes . . . and as a wound pack.

Today in both military and civilian circles the superiority of petrolatum applications is generally conceded—because they are bland and non-adherent, and appear to permit more rapid healing than tissue-devitalizing escharotics . . . also they are non-irritant and non-stimulating.

"Vaseline"* Petrolatum Gauze Dressings are strips of sterile, fine-meshed (44/36) absorbent cotton gauze, uniformly saturated in a sterile atmosphere with sterile white petroleum jelly, accordion-folded, and heat-sealed in moisture-proof aluminum foil envelopes. When drawn to full length, they are 3 x 36 inches, packed 6 envelopes to the box. They are thus dependably sterile . . . protected against extremes of temperature and humidity . . . and stable for indefinite periods. Ready for immediate use at any time, any place—and as convenient in operating and emergency rooms and in ambulances, as on the wards.

Order from your dealer—*save the time of your staff,* and be *sure* of absolute sterility at all times!

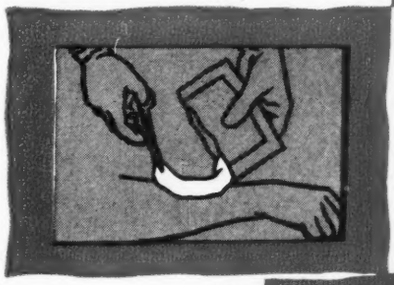
BAYBANK

BAYBANK PHARMACEUTICALS, INC.
17 STATE STREET • NEW YORK 4, N. Y.
Division of Chesebrough Mfg. Co. Cons'd

Baybank Pharmaceuticals, Inc.—a subsidiary of the world-famous Chesebrough Mfg. Co. Cons'd—has been established to bring to the medical profession a series of distinctively new ethical medicaments, progressively formulated, authoritatively tested, and of lasting merit.

bland, non-adherent, non-irritant
in INDIVIDUAL Sterile PACKAGES
for dressing, covering or packing

1 Individual aluminum-foil envelope is cut open along the lengthwise lamination with sterile scissors.



2 With sterile forceps, one end of "Vaseline" Sterile Petrolatum Gauze Dressing is pulled out, while envelope is held with other hand.

3 The emerging end of dressing is applied to wound (at the same time that pleated portion is withdrawn), with a motion similar to that used with a roller bandage. Dressing may be cut into strips of preferred dimension, or folded into pads of thickness desired, or used full length.

*Trade-Mark
Reg. U.S. Pat. Off.

NEWS . . .

W.H.O., Heart Institute Bills Passed by House and Senate

WASHINGTON, D.C.—President Truman in a special message to Congress May 24 recommended a five-point expansion of the Social Security laws. He proposed an increase in taxes to finance the program, and that the date for increasing the tax rate from 1 per cent to 1½ per cent be moved forward from Jan. 1, 1950, to Jan. 1, 1949.

The President asked for coverage for some 20,000,000 more persons and a 50 per cent increase in the present average of about $25 a month paid retired workers. He urged more adequate unemployment insurance benefits and increased federal benefits to match more fully state aid for dependent children, the needy, aged and blind.

The Senate passed and sent to the House May 24 a bill to authorize creation of a National Heart Institute in the U.S. Public Health Service. The bill authorizes federal grants to hospitals, universities, laboratories and other agencies for heart disease research.

The subcommittee on labor and public welfare held further hearings on S. 1320 to provide a national health insurance and public health program and S. 545 to create an independent national health agency. Dr. Marjorie Shearon, a specialist on public health legislation, expressed her views on the proposed measures.

On May 20, the House rules committee cleared the World Health Organization measure for House action and on May 28, the House passed the legislation by voice vote. The Senate has already passed a similar but not identical bill. The House authorized an appropriation not to exceed $1,920,000 in each year as the U.S. contribution.

V.A. Medical Lectures

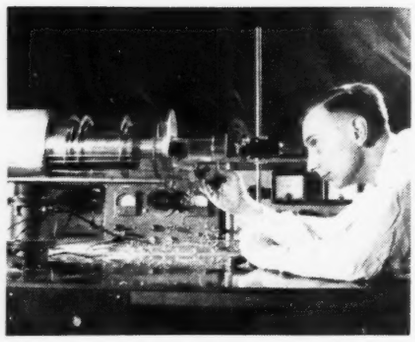
WASHINGTON, D.C.—Veterans Administration hospitals are offering medical lecture programs to residents and other medical personnel, V.A. has announced. Some of the nation's leading specialists and lecturers will discuss latest developments in medicine. V.A. hospital managers invite special teachers to deliver lectures, present demonstrations or conduct clinics.

Participants in the medical lecture program, as well as topics to be presented, are selected by the manager in collaboration with the hospital's Deans Committee.

NEWS . . .

New X-Ray Tube Will Increase Brightness of Fluoroscopic Images

PITTSBURGH.—Announcement of an x-ray tube which will increase the brightness of fluoroscopic images by as much as 500 times was made by Dr. J. W. Coltman of the Westinghouse Research Laboratories here last month. The new development is the result of four years of intensive study aimed at improving the diagnostic effectiveness of fluoroscopic images, Dr. Coltman said.



New x-ray tube increases brightness of fluoroscopic image 500 times.

The new amplifying unit consists of a high vacuum tube that electrostatically focuses and accelerates an electron stream, according to an announcement released by the laboratories. "The perfected device will take the form of an attachment for standard fluoroscopic equipment," the announcement said.

Future possibilities for fluoroscopy with the additional amplification now expected are manifold, it is pointed out. Both patient and doctor will save time and cut down on the length of the exposure to x-rays.

"The image amplifying system is just emerging from the research stage," Dr. Coltman explained. "Many months of perfection and design engineering remain to be done before the device is commercially available. The research has, however, irrefutably proved the practicability and immense importance of the device."

Laboratory officials added that it would be "at least a year or two" before the new equipment is available commercially.

Navy Dental Corps Adopts Intern Program

WASHINGTON, D.C.—The navy dental corps will have an intern program commencing this fall, R. Adm. Clifford A. Swanson, Medical Corps, U.S.N., has announced. A plan has been outlined to accept for appointment in the dental corps of the regular navy twenty members of the graduating classes of civilian dental colleges for a six months' course of postgraduate instruction at the Naval Dental School, National Naval Medical Center at Bethesda.

The postgraduate instruction will be followed by six months of intern training in naval hospitals or similar activities. Naval hospitals approved by the committee on hospital dental service of the American Dental Association for the intern training program will be utilized.

Want Oleo for Armed Forces

WASHINGTON, D.C.—A bill asking authorization for use of oleomargarine in the armed forces has been introduced in the House. The bill would provide that oleomargarine or butter substitutes be used only for cooking purposes, except to supply an expressed preference therefor or for use where climatic or other conditions render the use of butter impracticable. Numerous hearings have already been held concerning the use of oleomargarine by the armed forces.

How to turn refrigeration bills into good news

Can be done—if you put Meter-Miser compressors to work for you! Remotely installed with new or old refrigerated fixtures, these sealed-in-steel rotary units cut refrigeration bills 'way down and do it year after year. Proof? Ask any of over 4 million satisfied users. Better yet, call in your Frigidaire Commercial Dealer and get complete facts. Find name in Classified Phone Directory. Or write Frigidaire Division, General Motors Corp., Dayton 1, Ohio; Leaside 12, Ont.

Revolutionary Frigidaire Remote Meter-Miser backed by Special 5-Year Warranty

How the FRIGIDAIRE METER-MISER saves current, saves maintenance

Saves Current Because it's the simplest refrigerating unit ever built. Parts—made of the finest materials obtainable—are mirror-finished to reduce current-wasting friction to a minimum. Motor is specially cooled, maintains top efficiency even under peak loads. No pistons, piston pins, or connecting rods.

Saves Maintenance Because the compressor and motor are sealed in steel and oiled for life—damaging dirt, dust and moisture *can't* get in. No belts, no pulleys, no seals. Entire remote type Meter-Miser is 25% to 50% lighter than conventional units, can be lifted by one man. Uses Freon 12, the *safe* refrigerant.

Saves Space, Too—so compact, so attractive, can be tucked into almost any space you desire—can be hung from the ceiling, or placed on a shelf. Nothing to soil or tear customers' clothes.

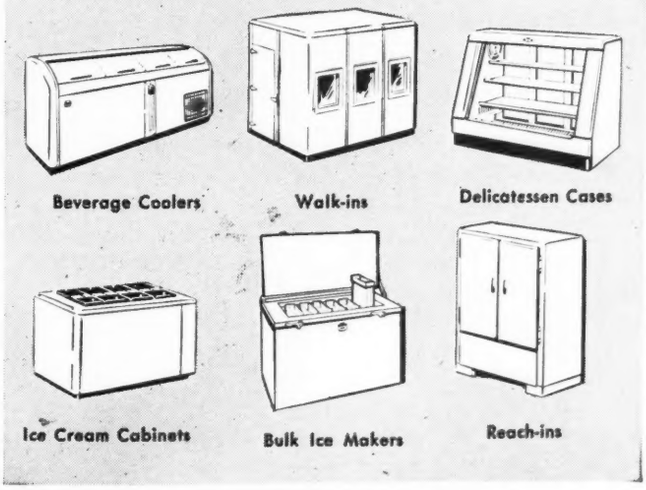
Three Basic Things to Look for When You Buy Refrigeration

A full line of *products* you can depend on, a *name* you can depend on, a *dealer* you can depend on. Get *all three* with Frigidaire.

You're twice as sure with two great names

FRIGIDAIRE made only by GENERAL MOTORS

FOR NEW OR REPLACEMENT USE WITH MOST REFRIGERATED FIXTURES



Beverage Coolers **Walk-ins** **Delicatessen Cases**

Ice Cream Cabinets **Bulk Ice Makers** **Reach-ins**

REACH-IN REFRIGERATORS • DISPLAY CASES • COMPRESSORS • COOLING UNITS • CONTROLS • WATER, BEVERAGE, MILK COOLERS ICE CREAM CABINETS • HOME AND FARM FREEZERS • AIR CONDITIONERS • ELECTRICAL APPLIANCES FOR THE HOME

NEWS . . .

Joint Program of Research in Medicine and Physical Sciences

WASHINGTON, D.C.—A cooperative program of fundamental scientific research in physical and medical fields has been agreed upon by the U.S. Atomic Energy Commission and the Office of Naval Research, according to an A.E.C. announcement. The work is in fields in which the two agencies have a common interest and will be carried on in hospitals, universities, nongovernmental laboratories and other research institutions. The joint support of the program will ensure coordination of research in fields in which there is a serious shortage of qualified scientific personnel.

The Atomic Energy Commission will make available up to $1,000,000 for medical and biological research for the one-year joint program. Twenty-nine medical and biological research contracts, including cancer studies, will be financed entirely by A.E.C. All contracts selected under the joint program for A.E.C. partial or entire financing will be administered by the Office of Naval Research.

Hold Pharmacy Institute

PRINCETON, N.J.—An institute on hospital pharmacy was conducted jointly by the American Hospital Association, the American Pharmaceutical Association and the American Society of Hospital Pharmacists here the week of June 28. Planned as an integrated and intensive study of hospital pharmacy, the institute program featured discussion periods, texts, motion pictures and slides. Hospital pharmacy administration, manufacturing technics and special formulas, and information on new drugs were presented in lectures and panel discussions.

A.Ph.A. Holds Meeting

WASHINGTON, D.C.—Leaders in the profession of pharmacy and pharmaceutical industry met here in May to dedicate a national war memorial to all pharmacists who served in the wars of our country and to hold professional conferences. Close to 200 pharmaceutical educators, state board and state association officials and other key men in the profession and drug industry attended. The meetings dealt with pharmaceutical services in relation to any future national emergency, and the profession's relation to the nation's health needs in either peace or war.

NEWS . . .

Representatives Pass Southern Regional Education Measure

WASHINGTON, D.C. — The House-passed measure granting the consent of Congress to the compact on Southern regional education went to the Senate floor May 6. The compact concerns an agreement entered into by some fourteen Southern states to set up regional universities in the medical, dental, veterinary and similar fields in the South. The Constitution of the United States requires the consent of Congress for a state to enter into any agreement or compact with another state.

An amendment offered by Senator Morse specifying that none of the proposed schools should apply entrance qualifications based on race, creed or color has stymied Senate action in the matter.

The future of Meharry Medical College for Negroes is involved in that a tentative agreement had been reached to establish a board of control for Southern regional education to administer Meharry. Under this agreement, each of the Southern states would make an annual contribution to the institution whose financial plight will not permit its continued operation otherwise.

Meharry College trains Negro doctors, dentists and nurses and helps to supply medical personnel to the 7,000,000 or so Negroes in the Southeast.

George Washington Hospital to Treat Mental Patients

WASHINGTON, D.C.—George Washington University Hospital announced May 17 that it is now prepared to give modern treatment to nervous and mental patients. It will offer a broad program of occupational therapy to aid in the recovery of private mental patients, including those who undergo the well-known lobotomy operation developed here eleven years ago by Dr. Walter Freeman and Dr. James W. Watts. Heretofore such convalescent care has been offered only at St. Elizabeths, restricted to federal patients, and at Gallinger, the city hospital for the indigent ill.

The entire sixth floor of the new 405-bed general hospital will be turned over for the use of neurologic, neurosurgery and psychiatric patients. For the weeks or months required for convalescent care, there will be available for these patients beautifully decorated lounge solariums, an air-conditioned gymnasium, freedom to play bridge, or dance or engage in creative arts or crafts. Acutely disturbed patients will be kept in a closed section.

The departments of psychiatry, neurology and neurological surgery are working closely together under direction of the teaching staff of the G. W. University School of Medicine. The psychiatry department is directed by Dr. Winfred Overholser, professor of psychiatry and superintendent of St. Elizabeths. The department of neurology and neurological surgery is directed by Dr. Walter Freeman, professor of neurology, and Dr. James W. Watts, professor of neurological surgery. The hospital expects soon to have resident physicians in both neurology and neurosurgery.

Senior students of the school of medicine will have facilities for study on the sixth floor and will attend the neurology clinic for the indigent to be held in the outpatient department. The laboratory of neurology at the University School of Medicine is working with the hospital department of psychiatry and neurology.

NEWS . . .

Announce Internships for Graduates of Hospital Administration Courses

MINNEAPOLIS. — Internship appointments have been announced as follows for members of the graduating class in the hospital administration course at the University of Minnesota:

Herbert A. Anderson, University of Michigan Hospital, Ann Arbor. Jerome Bieter, Rhode Island General Hospital, Providence. Frederick S. Burd, W. K. Kellogg Foundation, Battle Creek, Mich. Earl G. Dresser, Abbott Hospital, Minneapolis. Aileen E. Foley, Johns Hopkins Hospital, Baltimore. Donald Freeman, University Hospital, Minneapolis. Stephen B. Fuller, California Hospital, Los Angeles.

Robert E. Griffiths, Columbia Hospital, Milwaukee. Rodney Hemsworth, New Jersey Medical Center, Jersey City. Theodor L. Jacobsen, Swedish Hospital, Minneapolis. Leroy N. McKenney, Lowell General Hospital, Lowell, Mass. David E. Olsson, San Jose Hospital, San Jose, Calif. Telmer O. Peterson, University Hospitals, Cleveland. Bruce Root, Kahler Corporation, Rochester, Minn.

William F. Schueller, Baylor University Hospital, Dallas, Tex. George H. Stone, Vancouver General Hospital, Vancouver, B.C. Russell Williams, St. Francis Hospital, San Francisco. Kenneth E. Wolz, Charles T. Miller Hospital, St. Paul. William Weeks, California State Department of Health, San Francisco.

NEW HAVEN, CONN.—Internship and administrative appointments have been announced as follows for members of Yale University's graduating class in hospital administration:

George W. Brooks, Joseph H. Pratt Diagnostic Hospital, Boston. Nelson F. Evans, Grasslands Hospital, Valhalla, N.Y. Edgar L. Geibel, Genesee Hospital, Rochester, N.Y. Dr. Joseph H. Gerber, Peter Bent Brigham Hospital, Boston.

Henry B. Kidder, Joseph H. Pratt Diagnostic Hospital, Boston. Dr. Hilda H. Kroeger, Grace-New Haven Community Hospital, New Haven, Conn. Edmund R. Mattos, Massachusetts General Hospital, Boston. Ernest M. Sable, Beth Israel Hospital, Boston.

CHICAGO.—The program in hospital administration at Northwestern University has announced that students finishing academic work in June and August have received the following appointments for administrative internship:

Harry C. Bach, Springfield City Hospital, Springfield, Ohio. Ernest H. Bennett, Memorial Hospital, South Bend, Ind. Eileen G. Damiani, St. Luke's Hospital, Chicago. Anthony S. Dickens, Hermann Hospital, Houston, Tex. Robert V. Fay, Bridgeport Hospital, Bridgeport, Conn. Blanca B. Garcia, W. K. Kellogg Foundation, Battle Creek, Mich. Dr. Pedro A. Garcia, W. K. Kellogg Foundation, Battle Creek, Mich. James R. Gersonde, Harper Hospital, Detroit.

Sterling E. Gill, Provident Hospital, Chicago. Anthony C. Guzik, Samaritan Hospital, Troy, N.Y. Alice E. Harrison, Women and Children's Hospital, Chicago. Carl T. Heinze, State University of Iowa Hospitals, Iowa City. Joseph M. Henry, Watts Hospital, Durham, N.C. Robert E. Henwood, County of Los Angeles, Calif. Joseph S. Hew, Council of Rochester Regional Hospitals, Inc., Rochester, N.Y. Roy C. House, Methodist Hospital, Indianapolis.

Stephens A. Lott, W. K. Kellogg Foundation, Battle Creek, Mich. William A. McAlexander, Waverly Hills Sanatorium, Waverly Hills, Ky. Josue Pagan-Carlo, Touro Infirmary, New Orleans. John E. Paplow, Herrick Memorial Hospital, Berkeley, Calif. Obed W. Poling, Ohio Valley General Hospital, Wheeling, W. Va. Carl D. Rinker, St. Luke's Hospital, Chicago. Herbert R. Rodde, St. Luke's Hospital, Duluth, Minn. John W. Shy, Latter-Day Saints Hospital, Salt Lake City, Utah. Charles A. Turner Jr., Syracuse Hospital, Syracuse, N.Y. Robert W. Wencil, St. Luke's Hospital, Milwaukee. Kenneth L. Winters, Malden Hospital, Malden, Mass.

NEW YORK.—Columbia University students of hospital administration will begin internships in accordance with the following schedule of appointments, the university has announced:

Dr. Hsi-Ming Chang, Nanking Central Hospital, Nanking, China. Szetu Dju, Northern Nebraska Methodist Hospital, Omaha, Neb. Herbert G. Gillis, Grace Hospital, Detroit. James E. Jenkins, Roosevelt Hospital, New York City. Dr. Carman J. Kirk, St. Luke's Hospital, New York City. William A. Kozma, Nassau Hospital, Mineola, L.I. John C. Lindemann, Lenox Hill Hospital, New York City. Thurston W. Long, University of Pennsylvania Hospital, Philadelphia.

James F. McLaughlin, Caledonian Hospital, Brooklyn, N.Y. Sherwood A. Messner, New York Hospital, New York City. Gilbert Moss, Massachusetts General Hospital, Boston. Dr. F. Lloyd Mussells, Strong Memorial Hospital,

NEWS . . .

Rochester, N.Y. Dr. Ellsworth T. Neumann, Roosevelt Hospital, New York City. Mary E. Patterson, W. K. Kellogg Foundation, Battle Creek, Mich.

Francis M. Petri, St. Barnabas Hospital, New York City. Roy C. Stephenson, Harper Hospital, Detroit. Alfred Van Horn, East Orange General Hospital, East Orange, N.J. Robert E. Wallace, Youngstown Association Hospital, Akron, Ohio. William Woods, Strong Memorial Hospital, Rochester, N.Y. Anthony J. De Luca, Menorah Hospital, Kansas City, Mo. Anthony W. Esposito, Jewish Hospital, Cincinnati.

TORONTO, ONT.—Internship appointments for members of the first graduating class of the course in hospital administration at the University of Toronto have been announced by Dr. L. O. Bradley, head of the department. The appointments are:

Dr. Benjamin G. Rothman, Denver General Hospital. Harold R. Cathcart, W. K. Kellogg Foundation, Battle Creek, Mich. Walter James Birch, Toronto East General and Orthopaedic Hospital. Dr. George W. Peacock, Kingston General Hospital, Kingston, Ont.

Hold Southwest Institute

DALLAS, TEX.—Nine southwestern states and Puerto Rico were represented by seventy-five hospital administrators attending the second Southwestern Institute conducted by the American College of Hospital Administrators here last month in cooperation with the Texas Hospital Association and the Dallas Hospital Council. The program of lectures and discussion periods revolving about current hospital administrative problems also included field trips by bus to Dallas and Fort Worth hospitals.

Morning coffee at the Southwest Institute.

COMING MEETINGS

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Elks Club, Los Angeles, Oct. 18-22. Extension Courses: Advanced Course, Duluth, Minn., Aug. 23-27. Regular Course, Los Angeles, Oct. 25-29.

AMERICAN DIETETIC ASSOCIATION, Hotel Statler, Boston, Oct. 18-22.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Traymore Hotel, Atlantic City, Sept. 19, 20.

AMERICAN CONGRESS OF PHYSICAL MEDICINE, Hotel Statler, Washington, D. C., Sept. 7-11.

AMERICAN HOSPITAL ASSOCIATION, Traymore Hotel, Atlantic City, Sept. 20-23.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, Hotel Pennsylvania, New York City, Sept. 7-9.

AMERICAN PROTESTANT HOSPITAL ASSOCIATION, Atlantic City, N. J., Sept. 17-19.

NEBRASKA HOSPITAL ASSOCIATION, Cornhusker Hotel, Lincoln, Nov. 17, 18.

1949

TEXAS HOSPITAL ASSOCIATION, Buccaneer Hotel, Galveston, April 19-21.

ESPECIALLY DURING

Post-Infectious Recovery

Following recovery from severe infectious disease, acute nutritional deficiencies must be corrected promptly if maximum speed of recovery is to be attained. The nutrient imbalance which exists during this period usually involves not only members of the vitamin B complex, but also proteins as well.

The delicious food drink made by mixing Ovaltine with milk is a pleasant and effective means of increasing the intake of virtually all essential nutrients. Easily digested and of low curd tension, it does not impose an undue digestive burden, and is frequently acceptable when other foods are refused. Three glassfuls daily supply significant amounts of B complex and other vitamins including ascorbic acid, biologically adequate protein, readily digested fat and carbohydrate and the important minerals copper, iron, and calcium. This dietary supplement is enjoyed by all patients, young and old, and is taken without difficulty in recommended amounts. Hence it might well be included routinely in the dietary of convalescence.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.

Ovaltine

Three servings daily of Ovaltine, each made of ½ oz. of Ovaltine and 8 oz. of whole milk,* provide:

CALORIES	669	VITAMIN A	3000 I.U.
PROTEIN	32.1 Gm.	VITAMIN B_1	1.16 mg.
FAT	31.5 Gm.	RIBOFLAVIN	2.00 mg.
CARBOHYDRATE	64.8 Gm.	NIACIN	6.8 mg.
CALCIUM	1.12 Gm.	VITAMIN C	30.0 mg
PHOSPHORUS	0.94 Gm.	VITAMIN D	417 I.U.
IRON	12.0 mg.	COPPER	0.50 mg.

*Based on average reported values for milk.

NEWS . . .

Ten State Associations Announce Names of Newly Elected Officers


R. C. Warren

LITTLE ROCK, ARK.—Marvin H. Altman, superintendent of the Sparks Memorial Hospital, Fort Smith, Ark., became president of the Arkansas Hospital Association during its annual conference here last month. R. C. Warren, Davis Hospital, Pine Bluff, was named president-elect.

Other officers elected during the meeting were: vice president, Della A. Walters, administrator, Conway Memorial Hospital, Conway; secretary, K. W. Newman, administrator, University Hospital, Little Rock; treasurer, C. C. Cooper, administrator, City Hospital, Magnolia; delegate, Ruth Beall, administrator, Arkansas Children's Home and Hospital, Little Rock; alternate, John Gilbreath, administrator, Baptist State Hospital, Little Rock.

LOS ANGELES.—Wilbur L. Krell was named president-elect of the Association of California Hospitals here at a recent meeting as Leroy R. Bruce, superintendent of Los Angeles General Hospital, took over the association presidency. Other officers named included: first vice president, Margaret J. Wherry, Los Angeles; second vice president, V. W. Olney, San Francisco, and treasurer, Thomas P. Langdon, San Francisco.

BILOXI, MISS.—Robert F. Whitaker, superintendent of Emory University Hospital, Atlanta, Ga., was named president-elect of the Georgia Hospital Association at a meeting here recently. Head of the Georgia group for 1948 is George R. Burt, superintendent of Atlanta's Piedmont Hospital. Fred Walker, superintendent of Grady Hospital, Atlanta, was reelected secretary-treasurer.

BALTIMORE.—Benjamin W. Wright, superintendent of Memorial Hospital, Cumberland, Md., was named president-elect of the Maryland-District of Columbia Hospital Association at the annual spring conference May 27. Mr. Wright succeeds Brady J. Dayton, superintendent of Peninsula General Hospital, Salisbury, Md., who resigned. Hospital administrators and their trustees from Delaware, Maryland and the District of Columbia attended the two day meeting. J. G. Capossela, superintendent of the Central Dispensary and Emergency Hospital, Washington, D.C., presided.

ALBUQUERQUE, N.M.—Roy W. Bashow, administrator of the Carrie Tingley Hospital at Hot Springs, was named president-elect of the New Mexico State Hospital Association at its third annual meeting held here recently. Mary Young of the New Mexico Miners' Hospital, Raton, became president of the association. Other officers elected were: vice president, Sister Mary Jude, St. Joseph Hospital, Albuquerque, and secretary-treasurer, James J. Connelly, Raton.

DURHAM, N.C.—E. T. McKeithan, administrator, Moore County Hospital, Pinehurst, N.C., was elected president of the North Carolina Hospital Association at a state hospital association meeting recently. Other officers elected by the association were: secretary-treasurer, Sample B. Forbus, director, Watts Hospital, Durham, N.C., and A.H.A. delegate, F. Ross Porter, Duke Hospital, Durham, N.C.

PHILADELPHIA.—W. W. Butts, manager, St. Luke's Hospital, Bethlehem,

NEWS . . .

Pa., was named president-elect of the Hospital Association of Pennsylvania for the year 1948-1949 at the twenty-sixth annual conference of the association here as H. S. Mehring of the Pennsylvania Hospital, Philadelphia, took over the presidency from N. J. Sepp, Western Pennsylvania Hospital, Pittsburgh. Other officers named by the association were: first vice president, William A. Hacker, McKeesport Hospital, McKeesport; second vice president, Sister M. St. Robert, St. Joseph's Hospital, Philadelphia; treasurer, Robert W. Gloman, Wilkes-Barre General Hospital, Wilkes-Barre, and executive secretary, John F. Worman, Harrisburg.

Mr. Mehring takes over from Mr. Sepp.

TACOMA, WASH.—Dr. K. H. Van Norman was named president-elect of the Washington State Hospital Association at a meeting here early in June. Doctor Van Norman is director of the Doctors Hospital, Seattle. Walter A. Heath, Tacoma, became president of the association. Other officers elected at the meeting were: first vice president, Sister Providence, Seattle; second vice president, Bergit Gundersen, Bellingham; third vice president, Chester Finkbeiner, Wenatchee; secretary-treasurer, Raymond F. Farwell Jr., Seattle, and executive secretary, Nina Mae Garner, Tacoma.

ROANOKE, VA.—James L. Foster of the Bluefield Sanitarium, Bluefield, W. Va., was named president of the Hospital Association of West Virginia at a meeting here recently. J. T. Lindberg, Fairmont, W. Va., is the new president-elect. Other officers are: vice president, P. J. Mehlinger, Morgantown, W. Va.; secretary-treasurer, J. Stanley Turk, Wheeling, W. Va.; board of trustees, Charles C. Warner and T. Harvey McMillan.

KITCHENER, ONT.—Jessie Wilson of the Brantford General Hospital, Brantford, Ont., was named president of the Regional Hospital Conference of Ontario Districts 1 and 2 at a hospital meeting here last month, attended by health and hospital leaders throughout the district. Sister Mary Pascal of St. Joseph's Hospital, Sarnia, was elected vice president, and Ray Copeland, Memorial Hospital, St. Thomas, was reelected secretary-treasurer.

Hawley and Norby Open Minnesota Blue Shield

MINNEAPOLIS.—Dr. Paul R. Hawley, executive officer of the Blue Cross-Blue Shield commissions, and Joseph G. Norby, president-elect of the American Hospital Association, were featured speakers here last month at a meeting inaugurating the Minnesota Blue Shield Medical Care Plan.

On behalf of other prepayment plans and hospitals throughout the nation, Dr. Hawley and Mr. Norby welcomed the addition of a doctor sponsored, medical prepayment plan in Minnesota.

Minnesota Blue Shield, which has been under consideration for several years by the Minnesota State Medical Society, will cooperate with Minnesota Blue Cross.

GROVER
TUBE SYSTEM
whisks your messages to their destinations throughout the hospital

with 

Here's a messenger that shoots swiftly and silently about the hospital on the thousand urgent or routine errands of the day—never makes a mistake, never dallies, never takes a day off, never has to be hunted up when wanted. Slip your message into the GROVER Carrier, drop it into the tube and in a flash it's at its destination—in another department, on another floor, in another building. Case histories, diet sheets, prescriptions, pharmacy requisitions, accounting information, small items and instruments, all kinds of communications are handled with speed, accuracy, privacy, silence—and with economy unequalled in any other method. Hospitals large and small use this excellent system to enhance efficiency and reduce costs. Any GROVER representative can tell you how and will be glad to consult with you on your specific objectives. No obligation, of course. Call any GROVER office or write for our Hospital Bulletin.

GROVER PNEUMATIC TUBE SYSTEMS
THE GROVER COMPANY
DETROIT 19, MICH.
Offices in Principal Cities

NEWS . . .

New Sites Approved for V.A. Hospitals

WASHINGTON, D.C.—The Federal Board of Hospitalization has approved acquisition of a new fifteen-acre site in Boston for a 1000-bed Veterans Administration general medical and surgical hospital, V.A. announced May 14. Approval has also been given for the acquisition of an additional three acres on the east side of Manhattan Island in New York City as a portion of the site for still another 1000-bed general medical and surgical hospital.

The Boston site is within a three-mile radius of downtown Boston and within a mile or so of the Harvard University Medical School. Moreover, it is readily accessible to the medical schools of Tuft and Boston universities.

The additional three acres acquired in New York City will be combined with three acres previously approved to form the total hospital site.

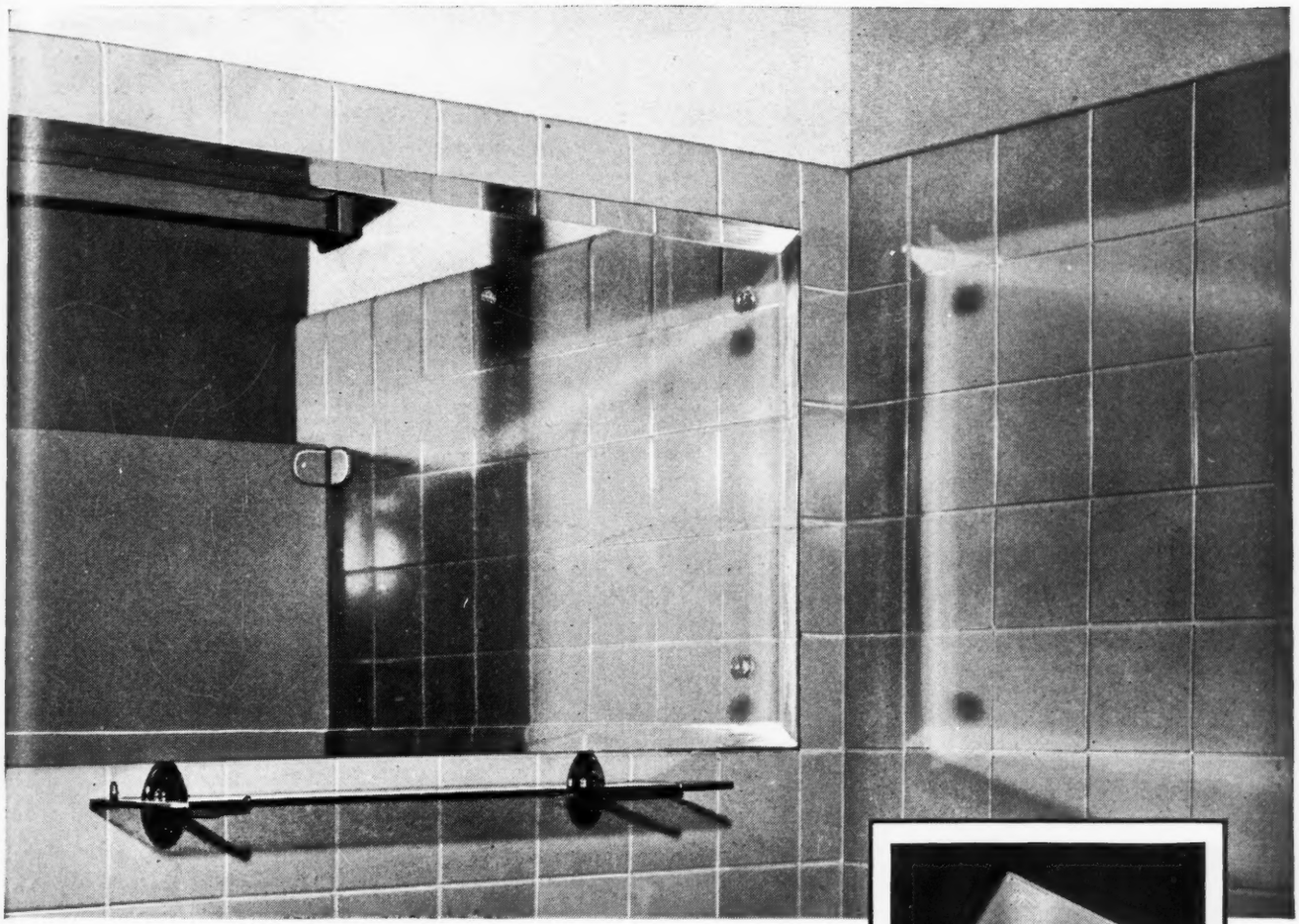
A.H.A. to Hold Accounting Institute

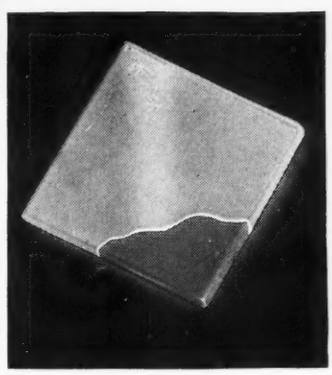
CHICAGO.—The fundamentals of efficient hospital accounting will be the subject of the seventh institute on basic accounting and business office procedures. The institute will be conducted by the American Hospital Association in Chicago July 26-30.

"Recognizing that efficient hospital accounting procedures are basic in the development of sound policies for hospital care," an association announcement said, "the institute committee has planned lectures and discussions to give a thorough knowledge of fundamental accounting tools and technics."

British to Amend Act

NEW YORK.—British physicians will not be enrolled in full-time salaried service for the government without specific legislation permitting such service, under an amendment to the Medical Service Act agreed to recently by Aneurin Bevan, minister of health, the *New York Times* reported last month. Mr. Bevan's statement was interpreted as a conciliatory move made necessary by continued strong opposition to the health act by the British Medical Association. Physicians in Britain have voted overwhelmingly against accepting service under the act as now written.





GENUINE PORCELAIN — millons of tiny glass-like particles melted together to form a hard, non-porous substance —is the lasting, lustrous finish of Veos Wall Tile. Fused to 20-gauge tempered steel at 1560° F., it provides permanent protection from rust and the highest resistance to wear. Veos tile won't crack, craze, or fade.

Only Veos Wall Tile Is PORCELAIN ON STEEL

Porcelain has remarkable qualities. It can be extremely colorful—it withstands years of hard wear—it's easy to keep clean. Armstrong's Veos Wall Tile is the only wall tile made of genuine porcelain permanently fused to a base of tempered steel. Because the porcelain and the steel contract and expand at the same rate, strains can't develop to cause cracks or crazing in the tile. That's the real secret of Veos Wall Tile's enduring beauty.

Veos tile can be installed quickly, neatly, and economically. It weighs less than one-third as much as clay-bodied tile, so walls don't have to be reinforced to support it. And Veos tile goes up over a lightweight, grooved fiberboard grid that assures perfect alignment always.

Many decorative designs are possible with Veos Wall Tile. It comes in six bright colors and many different sizes and shapes. It's ideal for operating rooms, clinics, washrooms, and dispensaries. Ask your local Armstrong contractor for full information about Veos Wall Tile or write today to Armstrong Cork Company, Building Materials Division, 5706 Frederick Street, Lancaster, Pennsylvania.

ARMSTRONG'S VEOS WALL TILE
Porcelain on Steel

NEWS . . .

Too Many Schools Are "Inadequate," Speaker Tells Nurses at Biennial Meeting

CHICAGO. — Continued widespread public support of nursing schools that are inadequate to do a proper training job is keeping open a number of schools that ought to be closed, Dr. Esther Lucille Brown of the Russell Sage Foundation in New York City declared in a stinging address which became one of the sensations of the Biennial Nursing Convention here last month.

Dr. Brown addressed a joint session of the American Nurses' Association, the National League of Nursing Education and the National Organization for Public Health Nursing. The three groups brought more than 10,000 nurses to Chicago for the fifteenth biennial meeting.

In her report, which was received with a mixture of excitement and indignation by an audience that packed Chicago's huge Coliseum, Dr. Brown stated that the 1250 schools now being operated with an average faculty of three and an average of fifty students each could produce better results if reduced to 300 schools with an average of 300 students.

Hospitals must realize that their future lies in in-service training for practical nurses and nurse's aides rather than in schools of the type now being operated, Dr. Brown said. Advanced training may be left to the more specialized professional schools, she added. Dr. Brown urged that the term "professional" be reserved for application only to those nurses with a true professional education. Throughout her talk, she referred to the "graduate bedside nurse" rather than the "professional nurse."

"The graduate bedside nurse has too much training for the majority of her simple duties and not enough training for some of her more complicated duties," Dr. Brown asserted.

In an important action, the house of delegates of the American Nurses' Association voted to admit 3000 qualified Negro nurses to full A.N.A. membership, even though such nurses may be barred from membership in district and state associations.

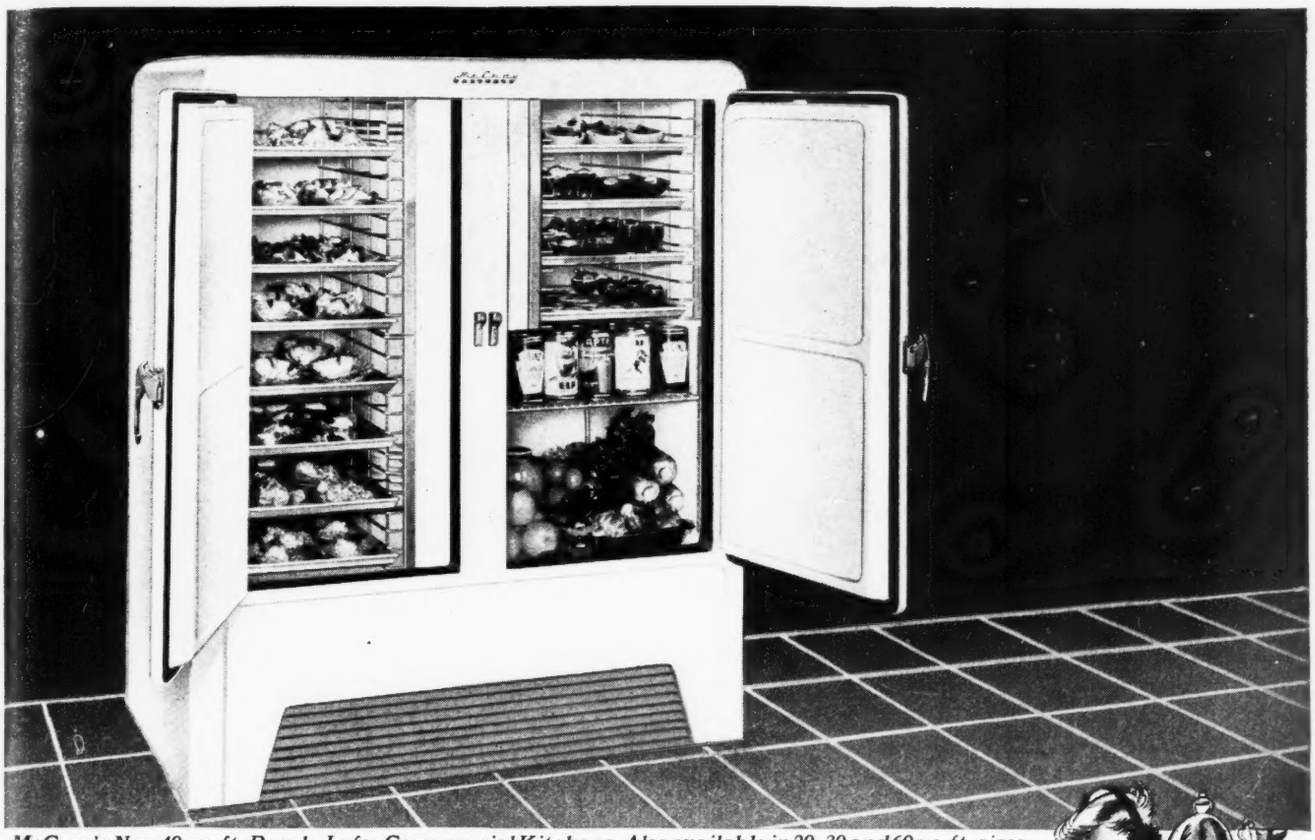
The delegates also voted to implement the economic security program outlined at the last biennial meeting in Atlantic City when a report from the committee on employment conditions was adopted without discussion. The report recommended that the American Nurses' Association board of directors should aid state nurses' associations in their economic security activities.

However, many observers who were present at the biennial meeting reported that the general feeling about the economic security movement was considerably cooler than it had been in Atlantic City two years ago.

The delegates also moved toward creating one national nursing association in place of the three professional and three nonprofessional organizations.

A.N.A. officers and board members elected include: president, Pearl McIver; first vice president, Janet M. Geister; second vice president, Mrs. Bethel McGrath; secretary, Mrs. Linnie Laird; treasurer, Lucy Germaine; board members, Mrs. Estelle Massey Osborne, Mrs. Myrtle C. Applegate, and Mrs. Elizabeth Porter.

New president of the National League of Nursing Education is Agnes Gelinas, R.N., Skidmore College Department of Nursing, New York. Ruth Sleeper, R.N., the outgoing president, was elected to the board of directors of the league.



McCray's New 40 cu. ft. Reach-In for Commercial Kitchens. Also available in 20, 30 and 60 cu ft. sizes

You get the benefits of genuine "Up from Under" refrigeration in McCray KOLDFLO

A controlled flow of cold air rising "up-from-under" protects all perishables from direct blasts—that's McCray's famous KOLDFLO system of refrigeration. KOLDFLO is exclusive in such refrigerators as this streamlined 40 cu. ft. Reach-In for commercial kitchens.

Now you can prepare salads, desserts, sauces and relishes in advance and store them until needed. All perishables are kept at the peak of freshness . . . ready to serve or to be used in preparing appetizing meals. Special racks for 36 trays . . . adjustable and removable metal bar-type shelves . . . full length service doors . . . all McCray quality features. Distributors in all principal cities. Check your telephone directory . . . or write directly to the McCray Refrigerator Company, 866 McCray Court, Kendallville, Indiana.

Go Modern with... McCray KOLDFLO

FEATURES

TEMPERATURE—instant, balanced control to suit your requirements . . . maintains proper degree of humidity . . . "on duty" 24 hours of the day . . . is self-defrosting.

CONDENSING UNIT — Self-contained, semi-hermetically sealed...engineered and adjusted for efficient, low cost operation.

BUILT FOR SERVICE—solid top-to-bottom service doors . . . full length compartments . . . smart, flush-designed hardware in satin chrome finish.

NEWS . . .

New Veterans' Hospitals Approved

WASHINGTON, D.C.—A 1000-bed Veterans Administration general medical and surgical hospital will be located in Oklahoma City, Okla., through the approval by the President and the Federal Board of Hospitalization of the acquisition of nine acres of land there, V.A. announced recently. The property adjoins the Oklahoma University School of Medicine and the state university hospital group, including the University Hospital and the Crippled Children's Hospital.

Bids for the construction of a 200-bed general medical and surgical hospital for veterans at Marlin, Tex., were opened here May 25. Contracts totaling $4,517,767 for the construction of a veterans' hospital at Saginaw, Mich., have already been awarded.

Existing V.A. hospitals and homes in operation as of the end of March totaled 126 with 119,617 beds. This number included 33 military and other hospitals transferred to V.A. Of new hospitals in the construction program, two have been completed, twenty-four were under contract, and sixty-five in the planning stage. Eighty-one sites for new hospitals had been approved.

Patients Get Malaria Following Transfusion

CHICAGO.—Two patients were infected with malaria through blood transfusions given at the Municipal Tuberculosis Sanitarium here, it was reported last month. The cases were not reported to the board of health, it was charged.

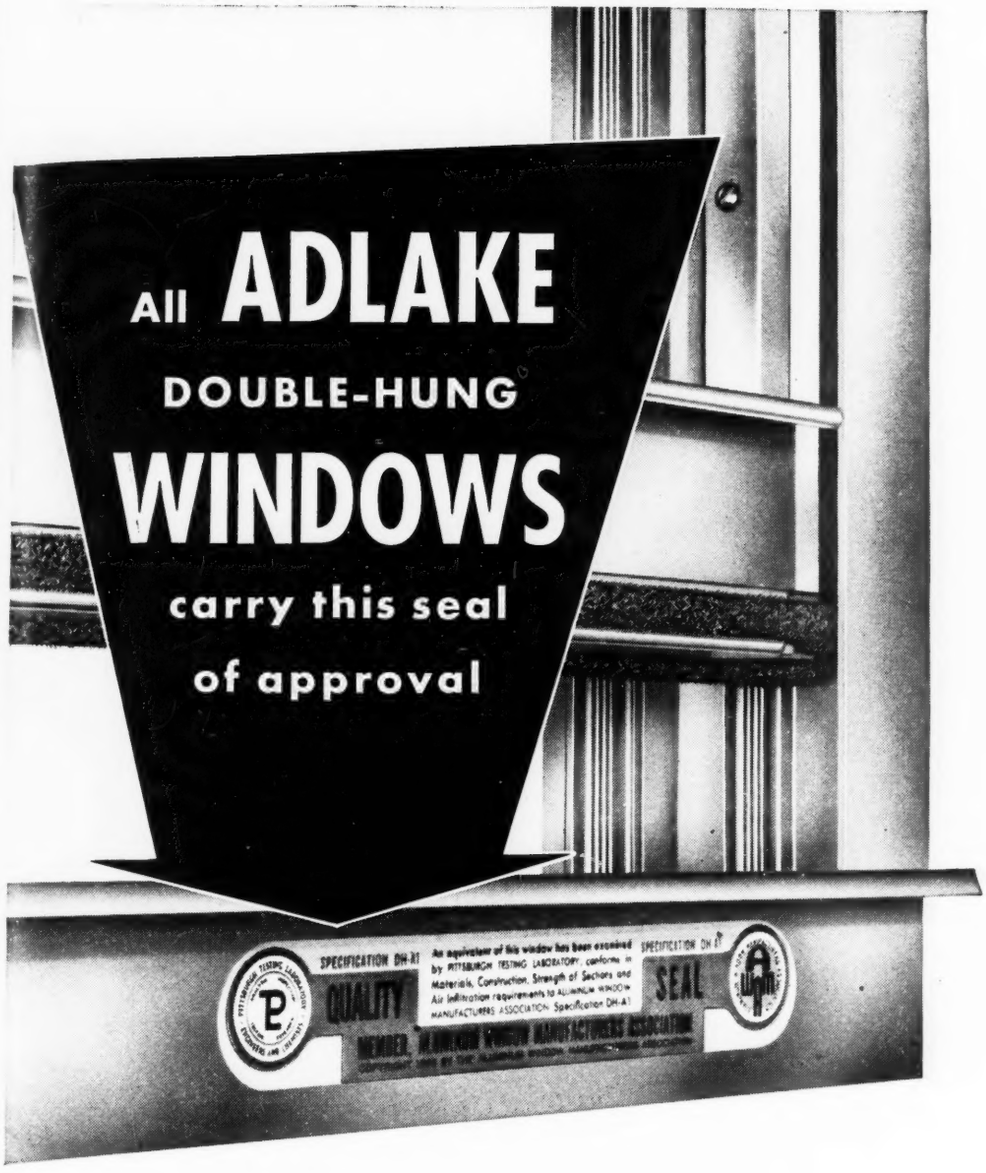
Dr. Herman N. Bundesen, president of the city board of health and a member of the sanatorium board of directors, said, "The law required that these cases should have been reported to the health department. This was not done, and we had no knowledge of them prior to the letter [an anonymous communication directed to Mayor Martin Kennelly]. The tuberculosis control officer has been notified to see that all such cases are reported at once hereafter."

Dr. Arthur W. Newitt, tuberculosis control officer at the sanatorium, acknowledged that two cases of malaria had occurred. "All symptoms of malaria in these two cases have been controlled at the sanatorium by appropriate treatment," he said.

Workshop for Supervisors at Galesburg, Ill.

CHICAGO.—A workshop on supervisory training in hospitals will be sponsored by the personnel committee of the American Hospital Association at Galesburg, Ill., during the week of July 12, according to an invitation issued by the committee, which functions under the association's Council on Administrative Practice. Co-sponsor of the workshop is the University of Illinois. The conferences will be held at the university's Galesburg division.

Among the purposes of the conferences will be: determination of the extent to which supervisory training can help improve hospital administration; study of specific problems in supervisory training; development of favorable attitudes toward training, and critical analysis of existing training programs.



--and meet all the specifications of the Aluminum Window Manufacturers' Association

The seal you see on every Adlake double-hung Aluminum Window is your guarantee of quality. It means that the window has met all specifications of the Aluminum Window Manufacturers' Association for quality of materials, soundness of construction, strength of sections, and air infiltration requirements.

This seal means you can install Adlake Aluminum Windows with confidence. It is concrete evidence that when you buy Adlake Windows, you are getting the most for your money—in long life, good looks, easy operation. Adlake Windows *pay for themselves* within a short time through *eliminating* expensive maintenance costs. No maintenance is required—no painting, nothing but routine washing.

Write today for complete data. Address: 1105 N. Michigan, Elkhart, Ind. No obligation, of course.

THE **Adams & Westlake** COMPANY

Established 1857

ELKHART, INDIANA

New York • Chicago

Adlake TRADE MARK

NEWS . . .

Would Continue Silver Nitrate for Newborn

NEW YORK.—Penicillin has not been shown superior to silver nitrate for use in the eyes of the newborn as a guard against infection, and its use without further experience would be a calamity, the *New York State Journal of Medicine* asserted in an editorial last month.

"It would be a calamity if a tried and certain method were discarded without further experience with another which has by no means been shown to be superior," the *Journal* editorial declared. "Perhaps there is a substitute which causes less reaction than silver nitrate, but we had better know more about that before the claim of infallibility is disseminated."

The *Journal* pointed out that a special committee of the New York Academy of Medicine, named in response to a request from the New York City commissioner of health for an opinion as to the desirability of changing the sanitary code to accept penicillin as a substitute, did not recommend any change, although it did suggest that hospitals, under adequate control, should be encouraged to make further studies.

"The special committee of the academy considering the problem," the *Journal* stated, "includes in its personnel an opthalmologist, a pediatrician and an obstetrician. Their opinion that the use of silver nitrate should be continued, pending the further study of the value of and practical considerations relating to the use of penicillin, preserves a tried and proved remedy in the use of which professional personnel has been trained over a long period of time."

Receive Higher Rank

WASHINGTON, D.C.—The rank of major general has been conferred upon three bureau chiefs of the U.S. Public Health Service, according to an announcement of Oscar R. Ewing, Federal Security Administrator. Raised in rank from brigadier to major general were Dr. R. C. Williams, chief, Bureau of Medical Services; Dr. C. L. Williams, chief, Bureau of State Services, and Dr. R. E. Dyer, director, National Institute of Health. The action was taken under authority of Public Law 425, passed February 28, as an amendment to Public Law 410, the "Public Health Service Act."

NEWS . . .

Carnahan Is President of Surgical Trade Group

CHICAGO.—Harry H. Carnahan, Huntington, W. Va., was elected president of the American Surgical Trade Association at its forty-sixth annual convention here last month. Other officers elected by the association included W. S. Stewart, Charlotte, N.C., vice president; Herbert L. Crowley, Boston, treasurer; Fred Hovey, Chicago, secretary, and William A. Peacock, Shreveport, La., and Robert Blackwood, directors.

Association members heard talks and took part in discussions covering all phases of medical and hospital business operations during the four days of the convention. Among the important speakers was Dr. Morris Fishbein, editor of the *Journal of the American Medical Association*. Dr. Fishbein reviewed the history of surgery and anesthesia and emphasized the importance today of the surgical team as opposed to the individual performer of a few years ago. Nevertheless, he said, "I am convinced from my own observations that the surgeon is in every sense of the word an artist, a virtuoso, and I am quite sure that if I were going to have a surgeon operate on me and he wanted a needle of a certain type with a certain eye and a certain width, a certain curve and a certain cutting edge and length, I would want him to have that needle. I don't care what anybody else says about his not needing that particular needle, I want that particular needle for that particular operation."

New officers of the A.S.T.A.: Seated (l. to r.): Treasurer, Herbert L. Crowly; President, Harry H. Carnahan; Past President, William H. Peacock. Standing (l. to r.): Hartmann Goetze William West, Robert Blackwood, Robert Anderson, Jr., and Fred Hovey.

Another nationally known speaker who addressed the convention was Dr. E. A. Rovenstine, professor of anesthesia at New York University College of Medicine. Doctor Rovenstine, who advocated building up teaching centers for medical anesthetists and interesting young doctors in anesthesia as a specialty, said that, nevertheless, the nurse anesthetist has been and still is an important factor in the field.

Seek to Equalize Retirement Benefits for Army, Navy Nurses

WASHINGTON, D.C. — The House-passed bill to equalize retirement benefits among members of the nurse corps of the army and navy has been reported favorably by the Senate committee on armed services. The purpose of the bill is to correct a situation whereby a number of retired army and navy nurses are paid according to a lower schedule than is currently in use for the majority of retired army and navy nurses.

For many years army and navy nurses were paid and retired under special legislation relating to nurses alone. Their active duty pay and, consequently, their retired pay have been much less than that of male officers. In addition to these inequities, disparities within the army and navy nurse corps themselves have arisen among various groups of nurses. The bill, now on the Senate calendar, seeks to correct such inequities.

NEWS . . .

Operating Rooms at Johns Hopkins Set Up for Television

BALTIMORE.—Two new major operating rooms containing provisions for televising surgical procedures were opened last month at Johns Hopkins Hospital, Baltimore. The two new rooms are part of a construction and renovation program to increase and improve general surgical facilities at the hospital, Dr. Edwin L. Crosby, director, said. In addition to the two operating rooms, an anesthetic room, a scrub room and sterilizing room have been constructed. One major operating room, two minor operating rooms, one anesthetic room, and one sterilizing room have been renovated.

Throughout the new rooms, every possible precaution has been taken against the hazard of explosion, it was explained. The flooring is a special conductive material, laid on a grounded wire mesh to permit the seepage of electrical potential developed by movement of persons or objects and reduce the danger of static spark.

The traditional white has been discarded in favor of "eye-ease" green tiling, designed to reduce eye strain for surgeons and assistants. The new rooms are fully air conditioned.

The observation galleries are constructed to give maximum visibility without actual presence in the operating room. Visitors will be on the floor above the operating room, situated directly over the operating table but behind glass. Binoculars will be provided. An intercommunication system has been installed to permit questions and answers between surgeon and observer.

Provisions for television resulted from experiments with this method of viewing operations at the Johns Hopkins Hospital in February 1947 when plans for the new rooms were being drawn. After considerable experimentation and study, a special mirror was ground for attachment to the operating room light. The mirror will be placed to reflect the best possible image of the operating site. When television is used, the camera will be placed on a platform at one side of the room and the camera lens will be focused on the mirror.

U.S. Observers Asked to Attend Assembly of W.H.O. in June

WASHINGTON, D.C.—The Department of State received an invitation to send one or more observers to the World Health Assembly, the first general conference of the World Health Organization which was convened in Geneva June 24. The invitation was extended by Dr. Brock Chisholm, executive secretary of the Interim Commission of the W.H.O., following the acceptance of the constitution of the World Health Organization by twenty-six members of the United Nations.

Dr. Chisholm's letter likewise constituted an invitation for this government to send a delegation to the Assembly in the event that the United States became a member of W.H.O. before the June Assembly. "The rôle of observer," Dr. Chisholm reminded, "does not carry the right of taking part in the discussions or the voting."

NEWS . . .

U.M.S. Enrollment Up Nearly 80 Per Cent

NEW YORK.—Enrollment of 324,549 persons in United Medical Service during 1947 represents an increase of nearly 80 per cent over the 1946 enrollment and brings the total to 730,293, Rowland H. George, president, stated in the annual report for 1947, issued last month. According to the report, participating physicians numbered 14,941 at the end of the year. During 1947 United Medical Service paid 49,022 doctors' bills, amounting to $2,200,738, on behalf of its members, the report indicated.

In a message to members, Mr. George said: "In three years of operation, United Medical Service has demonstrated that a voluntary plan designed to meet the pressing problem of the cost of medical care can win the support of the public and the medical profession. To augment that plan and adapt it to the changing needs of the public will be our continued aim."

United Medical Service, a nonprofit affiliate of Associated Hospital Service, New York's Blue Cross plan, is sponsored by the Medical Society of the State of New York and seventeen county medical societies.

Laundry Institute in Philadelphia

CHICAGO.—An institute on hospital laundry management will be conducted by the American Hospital Association in Philadelphia July 19-23. In addition to discussion of personnel, production and plant layout problems, the institute program will include consideration of relationship of the laundry to the total operation of the hospital; organization and staffing of the laundry department; washing methods and textile characteristics; laundry equipment, and planning and comparative costs, an association announcement explained.

Field trips to three Philadelphia hospitals are a special feature. The Pennsylvania Hospital Association and the Hospital Council of Philadelphia are additional institute sponsors. Administrators and staff members directly responsible for hospital laundry operation may receive further information and application forms from the Council on Administrative Practice of the association.

Hospitals know it, *too...*

A cat padding softly along represents a certain kind of *quiet* . . .

The kind of quiet that has been installed in hundreds of hospitals across the country . . . to speed the recovery of patients . . . to ease the nerves of doctors and nurses . . .

It's the quiet brought by Acousti-Celotex sound conditioning.

So effective is Acousti-Celotex* at banishing rattle, click, and clatter that *more buildings of ALL kinds are sound conditioned with Acousti-Celotex products than with any other material.*

Offices . . . schools . . . banks . . . churches and stores, as well as hospitals, have found that *quiet promotes well-being.*

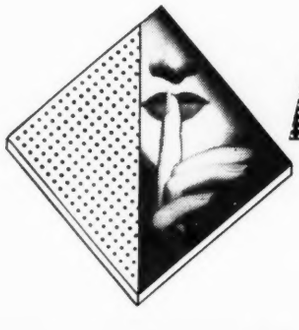
You are entitled to a *free* analysis of your own noise problem by a trained sound technician—your nearest distributor of Acousti-Celotex products.

His judgment gives you the benefit of the accumulated skill of a quarter century in sound conditioning . . . and experience in installing millions of square feet of Acousti-Celotex products.

Write us *today* for the name of your nearest distributor in the U. S. or Canada. *Sound conditioning is a sound investment.*

*REG. U. S. PAT. OFF.

THE CELOTEX CORPORATION, CHICAGO 3, ILLINOIS



ACOUSTI·CELOTEX

TRADE MARK REG. U. S. PAT. OFF.

Sound Conditioning

50th ANNIVERSARY CONVENTION ATLANTIC CITY Sept 20-23

PRODUCTS FOR EVERY SOUND CONDITIONING PROBLEM

NEWS . . .

A.H.A. Convention to Feature Honors for Nonpaid Workers

CHICAGO.—Recognition for outstanding contribution to voluntary hospitals by men and women serving on the board of trustees, auxiliary or other volunteer groups will be a feature of the American Hospital Association convention at Atlantic City September 21, according to a recent announcement.

Awards will be presented to fifty representatives chosen by an honor committee at a special honor night program. Nominations could be submitted by any state or provincial hospital association, hospital council, or member institutions of the association, it was explained.

Judges who will be members of the selection committee are: Graham L. Davis, president of the association; R. O. D. Hopkins, director of the United Hospital Fund, New York, and Anson Lowitz, vice president of the J. Walter Thompson Advertising Company and director of the Advertising Council for the 1948 student nurse recruitment campaign.

Practicing physicians, hospital employes, or paid workers in the health field are not eligible to receive awards, it was specified.

The association convention will also feature a national conference of women's service committees. Object of the conference is to bring together a large group of women representing all kinds of volunteer agencies serving hospitals. Chairman of the conference committee is Mrs. Morris Fishbein, director of the gift shop at Chicago's Lying-In Hospital and wife of Dr. Morris Fishbein, editor of the *Journal of the American Medical Association.*

Hint Special Draft of Doctors, Dentists

WASHINGTON, D.C. — Doctors, dentists and other special occupational groups may face a special draft in military manpower legislation now being prepared for congressional consideration and action, according to a story released in the *Washington Post.*

In the medical and dental groups, the story said, needs of the new preparedness program are so great that "older men and those with dependents" must be subject to call. The upper age limit for the medical draft is expected to be forty-five years, it was reported.

Immediate needs of army and navy medical departments "can probably be met largely out of the 8000 civilian physicians in their twenties whose professional education was paid for in part by the government," the *Post* writer said, attributing this opinion to a "high officer."

To Strengthen V.A. Staffs

WASHINGTON, D.C.—A plan to employ residents in medicine, surgery and psychiatry and add more part-time physicians to regional staffs was presented last month by Dr. Paul A. Magnuson, medical director of the Veterans Administration. Dr. Magnuson said these steps were needed to strengthen V.A. medical staffs. Several thousand beds in V.A. hospitals are closed for lack of medical personnel, it was reported.

NEWS . . .

V.A. Workers, Patients Eligible for Contests

CHICAGO.—Prizes are being given staff and volunteer workers in V.A. hospitals who encourage veterans to attempt writing projects through either their hospital publication, clubs, classes or contests. The Hospitalized Veterans Writing Project, 919 North Michigan Avenue, Chicago 11, is conducting the contest, which closes July 31.

To the V.A. hospital newspaper staff submitting a regular issue showing the greatest number of patients participating, a prize of $50 will be awarded, half of which is earmarked for new equipment and the other half for small prizes to encourage future contributors.

These two contests are among the ten announced by a group of editors and free lance writers who are sponsoring the Hospitalized Veterans Writing Project.

"The morale of many hospitalized veterans is difficult to maintain," declares Elizabeth L. Fontaine, syndicate writer and founder of the project, "and this annual writing contest is to encourage veterans to turn their thoughts into creative and imaginative channels. Much of the occupational therapy offered veterans is work with the hands. We are interested primarily in getting them to work with their heads."

The first prize offered V.A. staff workers, including librarians, Red Cross workers, and volunteers, is a new nineteen-volume reference set of the "World Book Encyclopedia," including free research of trained librarians as a time-saver for writers. Honorary awards include gift subscriptions in the name of the hospital to two writers' magazines. Mildred Whitcomb, associate managing editor of The MODERN HOSPITAL, is the judge of this contest. Herb Graffis, columnist on the *Chicago Sun-Times,* is judge of the $50 annual hospital newspaper award.

Three Cancer Clinics Open in Washington

WASHINGTON, D.C.—The new George Washington University Hospital opened its Warwick Cancer Detection Clinic here May 6. It is equipped to handle about eighty patients a month. Around July 1, Freedmen's Hospital also opened a cancer clinic.

Doctor's Hospital has also opened its new cancer detection clinic. Public interest manifested itself in a list of appointments which alone promised to keep the clinic busy for at least two-and-a-half months. The clinic will check approximately fifteen persons during each of the three half-day examination periods each week. The clinic will report its findings to the family physician of the persons examined.

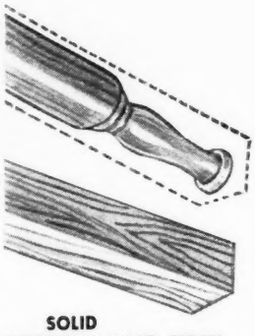
V.A. Revises Drug List

WASHINGTON, D.C.—The Veterans Administration has distributed a revised list of approved "decentralized-contract" drug items to pharmacists in its hospitals, centers and regional offices, E. Burns Geiger, chief of the V.A. pharmacy division, announced last month. At the request of physicians, V.A. pharmacists in the field can obtain items on the decentralized-contract list directly from manufacturers, it was explained.

WOOD *unparalleled for Quiet Service....*

CARROM SUITE "D" Hospital Modern
A suite of sound artistic merit, modern design, and highly serviceable construction. All drawers are made with Bar Pulls to emphasize the modern appearance.

CARROM FURNITURE CRAFTSMEN *Build* FOR THE DECADES!



SOLID NORTHERN HARD BIRCH
There is no better wood for institutional furniture than this . . . for all parts subjected to constant stress and strain. Basically sound and enduring materials are prerequisites for Carrom construction.

Engineers find in wood a superior material where natural resilience, high resistance to bending or compression are needed. But it is not these basic qualities alone that make wood the most desirable material for institutional furniture.

"Quiet service" is equally important . . . for in the institution, a calm, restful effect is demanded. Wood, in addition to its great strength, possesses a resilience and porosity that absorbs sound. A blow against wood may create a dull thud, but never a harsh, ear-splitting, clanging sound nor disturbing clatter or rattle when moved about.

But Carrom-built furniture offers still more than the natural strength and "quiet service" characteristic of wood. It is designed *exclusively for institutional use* . . . with a view to the years of serviceability expected from it . . . and to an institution's budget requirements.

Those who choose for strength, "quiet service" and economy, invariably choose Carrom Fine Wood Furniture, made by craftsmen who "build for the decades."

CARROM INDUSTRIES, INC., LUDINGTON, MICHIGAN
New York Office: 19 W. 44th St., Ralph Berg • Chicago Office: 1503 N. Sedgwich Ave., James L. Angle

CARROM

WOOD FURNITURE FOR HOSPITAL SERVICE

NEWS . . .

New York Fund Sets Campaign Goal at $8,000,000

NEW YORK.—A goal of $8,000,000 for its 1948 campaign, almost double the amount raised last year, has been announced by Henry C. Alexander, campaign chairman of the Greater New York Fund. The fund solicits corporations, partnerships and employe groups throughout the city in behalf of 423 local hospitals, health and welfare agencies.

In announcing the increased goal, Mr. Alexander outlined the financial situation confronting the agencies this year Costs of operation of the participating hospitals, health and welfare agencies have increased sharply. Last year, these agencies expended $124,514,000 to carry on their services. In 1938, when the fund was organized, agency expenditures were about $74,500,000, it was explained.

"The current year is a critical one for fund agencies," Mr. Alexander said. "In order to carry on their present activities they must obtain at least $41,000,000 in gifts from all sources. This sum is needed not for expansion, not for new developments, but in view of higher costs, simply to continue present activities. And it cannot be done unless more money is forthcoming from business.

"Yet, there is sound cause to believe that this goal is no more than is reasonable. Consultation with more than 100 business leaders indicates that most corporations want to do their proper share for local health and charitable causes and that business as a whole will readily understand why operating expenses have mounted so tremendously in recent years. Study of business giving to similar causes in other American cities shows that it is not out of line on a percentage basis with what business contributes elsewhere. In fact, corporations alone contribute from 30 to 40 per cent of hospital, health and welfare needs in many other communities."

Heart Hearings Under Way

WASHINGTON, D.C.—Hearings were started before the Senate Subcommittee on Health on S. 2215 to provide for research and control relating to diseases of the heart. Among those presenting their views on the proposed legislation was Dr. Leonard A. Scheele.

ABOUT PEOPLE

(*Continued From Page 78*)

Russell M. Tucker has been appointed superintendent of Masonic Hospital, Cushing, Okla., to succeed **Earl Benson,** who resigned to become head of Muskogee General Hospital, Muskogee, Okla. Mr. Tucker was assistant manager of Mercy Hospital Oklahoma City General for two and one-half years after serving five years in the army, where he was connected with hospital administration.

Robert A. Anderson has been appointed assistant superintendent Wyoming County Community Hospital, Warsaw, N.Y. Mr. Anderson, a graduate of the course in hospital administration, Columbia University, served his administrative internship at Johns Hopkins Hospital, Baltimore.

Robert Ashton Smith has been appointed assistant superintendent, Muhlenberg Hospital, Plainfield, N.J. Mr. Smith, a graduate of the course in hospital administration at Columbia University, served his administrative internship at University Hospitals of Cleveland.

Warren G. Rainier has been appointed assistant director of Mountainside Hospital, Montclair, N.J. Mr. Rainier completed a one year administrative internship at the North Side and South Side Units of Youngstown Hospital Association, Youngstown, Ohio, and on June 1, 1948 was awarded the degree of master of science in hospital administration by Columbia University.

Dr. I. Oscar Weissman, assistant director of Jewish Hospital of Brooklyn, N.Y., has been appointed executive director of Sydenham Hospital, New York City.

Irving Gottsegen has been transferred in the position of assistant director from the city institution of Montefiore Hospital, New York, to its country sanatorium at Bedford Hills, N.Y., where he is in executive charge. **Harry S. Apter** has been appointed associate director in charge of business management.

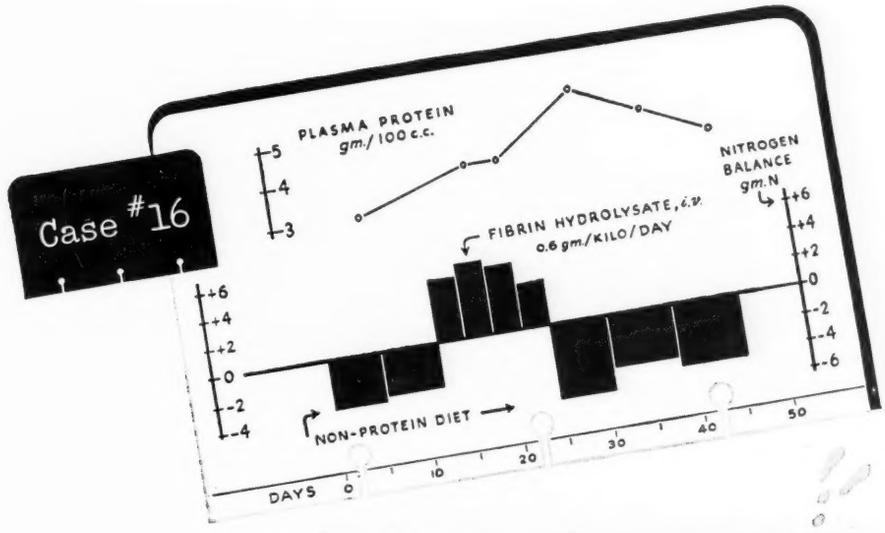
Herbert A. Schacht has assumed the position of administrator of Henry County Hospital, New Castle, Ind., replacing **M. Ezma Charlton,** who resigned recently after eighteen years as superintendent. Mr. Schacht had been administrative assistant at Hurley Hospital, Flint, Mich.

Harlan L. Paine Jr. has been appointed administrator of Winchester Hospital, Winchester, Mass. For the past few months Mr. Paine had been acting assistant director at Massachusetts General Hospital, Boston, where he had previously completed his administrative internship entitling him to the degree of master of hospital administration from Northwestern University.

Norman D. Bailey, for the last three years personnel director at Michael Reese Hospital, Chicago, has been appointed business manager of Lenox Hill Hospital, New York. Mr. Bailey, who came into the hospital field from an industrial relations position in industry, was a member of the faculty of the graduate course in hospital administration at the University of Chicago. While at Michael Reese he also taught a class in personnel administration at Chicago's Roosevelt College.

Jacques Cousin, a graduate of the Columbia University course in hospital administration, has completed his internship year at Harper Hospital, Detroit, and is remaining there as assistant director in charge of the outpatient department.

Francis C. Houghton will take over



A clue to nitrogen balance

and higher biological values in protein hydrolysates

Animal #16 lived in a metabolism cage at Abbott Laboratories on a non-protein diet. Then, in a condition of severe nitrogen depletion, she received a partial acid hydrolysate of fibrin intravenously at a high level of input as the sole source of nitrogen. Her response is charted above, showing the strong nitrogen retention and rapid improvement in the plasma protein level. Case #16 was one of many cases in an experiment which indicates that nitrogen in the form of a partial acid hydrolysate of fibrin is well retained and utilized when given to severely depleted animals.[1] A recently published clinical experiment with Aminosol suggests that the peptides which occur in hydrolysates of blood fibrin are well utilized in the human body.[2]

Aminosol 5% with Dextrose 5%, a fibrin hydrolysate, contains all the amino acids essential to good nutritive balance and can be administered with safety. It is sterilized by autoclaving, thoroughly tested for freedom from antigenicity, and is stable at room temperatures for two years or more. Dextrose has been added to afford a protein sparing action. Aminosol is virtually a sodium chloride-free solution and produces slightly more than twice the osmotic pressure produced by blood plasma. A recent publication is positive testimony on the biological efficiency of this product.[3]

Aminosol 5% with Dextrose 5% is supplied in 500 and 1000 cc. Abbott Intravenous Solution Containers, ready to use. Obtain added safety and convenience by using the sterile, disposable Venopak* equipment. Ask your Abbott Representative to give you more complete details on Aminosol, or write ABBOTT LABORATORIES, North Chicago, Ill.

Trade Mark for Abbott's disposable venoclysis unit.

Aminosol® 5% with Dextrose 5%

AN ABBOTT PARENTERAL PRODUCT

1. Frost, D. V., Heinsen, Jean, and Olsen, R. T. (1946), Arch. Biochem., 10:215, June. 2. Christensen, H. N., Lynch, E. L., Decker, D. G., and Powers, J. H. (1947), The J. Clin. Invest., 26:849, Sept. 3. Barborka, C. J., Carroll, W. W., and Hepler, O. E. (1947), Gastroenterology, 9:579, November.

the administration of Rutland Hospital, Rutland, Vt., July 1, succeeding **Mrs. Pearl C. Stone,** superintendent for twenty-five years. Mr. Houghton is now serving as assistant administrator of Butler Hospital, Providence, R.I.

Norman Hall, superintendent of Gifford Memorial Hospital, Randolph, Vt., since November, has resigned. **Mrs. Lilla Brunell,** formerly in charge of the hospital, has taken over the superintendent's post temporarily.

Elsie L. Delin, superintendent of Wilson Memorial Hospital, Sidney, Ohio, for the last three years, has resigned to take over the position of assistant administrator of Fort Hamilton Hospital, Hamilton, Ohio.

Department Heads

Julia S. Randall is the new director of nurses at Veterans Administration Hospital, Lincoln, Neb.

Dr. Mayo H. Soley has been appointed dean of the College of Medicine at the State University of Iowa to succeed the late **Ewen M. MacEwen.** Dr. Soley, who will assume his new duties in Iowa City about July 1, has been associated with the University of California Medical College since 1935. In addition to the deanship, he will serve as director of medical services at the State University of Iowa Hospitals, and as a research professor in the department of internal medicine at the medical college.

Dr. William B. Bean will join the staff of the State University of Iowa in September, when he becomes head of the department of internal medicine and professor of medicine at the medical college. Dr. Bean is a specialist in diseases of the heart, deficiency diseases, nutrition and acclimatization to heat.

Amy W. Greene, chief of the medical social service department of Johns Hopkins Hospital, Baltimore, since 1939, has resigned as of June 30. **Helen E. Woods,** case work supervisor at the same hospital, has been named as her successor.

Ruth M. Kahn has taken over her new duties as director of the dietary department at Michael Reese Hospital, Chicago. At the beginning of World War II, Miss Kahn was nutritionist for Harding Brothers and Williams, industrial caterers, and food production manager at the Dodge plant in Chicago. After V-E Day, she worked with U.N.R.R.A. as expert nutritionist for the displaced persons operation in Germany. Miss Kahn comes to Michael Reese from the Veterans Administration Hospital at Hines, Ill., where she served as chief dietitian.

Caroline Meyer has been appointed manager of Worcester House, nurses' residence of Passavant Memorial Hospital, Chicago. Formerly executive housekeeper of the Stevens Hotel and the Palmer House, Miss Meyer becomes the first manager of Passavant's newly acquired home for nurses.

Bertha Frook, a graduate of the class of 1931 of Evangelical Hospital, Chicago, is now director of nurses at that institution. A graduate of Loyola University, Miss Frook also attended the University of Chicago graduate school in nursing education. She was formerly director of nurses at Burnham City Hospital, Champaign, and at South Shore Hospital, Chicago.

Dr. Louis K. Alpert, formerly associated with Johns Hopkins Hospital and recently with George Washington University School of Medicine, has been appointed as chief of the medical service at the Mount Alto Veterans Administration Hospital, Washington, D.C.

Trustees

Frederick Brown has been elected president of the Hospital for Joint Diseases, New York City. Other officers

elected are **Louis M. Loeb,** chairman of the board; **Louis F. Rothschild,** treasurer; **William E. Loeb,** associate treasurer, and **Oscar M. Lazrus,** secretary. Vice presidents elected are **Norbert H. Bachmann, Oscar S. Rosner, Edgar L. Rossin** and **Louis J. Vorhaus.**

Isaac Albert has been elected for a fifth term as president of Jewish Sanitarium and Hospital for Chronic Diseases, Brooklyn, N.Y. Mr. Albert has been a member of the board for sixteen years.

David Bellamy was recently elected president of the board of directors of Rochester General Hospital, Rochester, N.Y.

Miscellaneous

Dr. W. P. Dearing

Dr. W. Palmer Dearing became deputy surgeon general, U.S. Public Health Service, May 17. He succeeds **Dr. James A. Crabtree.** Dr. Dearing is now second in command of the Public Health Service and will act as surgeon general in Dr. Scheele's absence. Since September 1946, the new deputy surgeon general has been chief of the Division of Commissioned Officers.

Dr. Dearing's wartime service included serving as assistant chief medical officer, and later as chief medical officer of the Office of Civilian Defense, and personnel work in the Health Division of U.N.R.R.A.

Dr. Dearing entered the Public Health Service in 1934 and his earlier assignments included poliomyelitis investigations and field studies of tuberculosis epidemiology.

Other new appointments include that of **Dr. Bruce D. Forsyth** as assistant surgeon general and chief of the Dental Division, succeeding **Dr. William Thomas Wright Jr.,** and **Dr. Eugene A. Gillis** who succeeds Dr. Dearing as chief of the Division of Commissioned Officers.

Constance Long

Constance Long, nurse consultant in the Division of Commissioned Officers, has been appointed chief of the nursing section, Hospital Division of the U. S. Public Health Service. She succeeds **Jessie MacFarlane** who will be transferred to the Office of the Chief of the Bureau of Medical Services.

Miss Long is a graduate of the Nassau School of Nursing and of New York University and has done graduate work at Teachers College, Columbia University. She joined the Public Health Service in 1944 as Nurse Education Consultant and, under the Cadet Nurse Corps program, was in charge of the Kansas City district office. Prior to her affiliation with the Public Health Service, Miss Long was director of clinical instruction and supervision at Bellevue Hospital, New York City, and later assistant professor in the School of Education, New York University.

Hiram Sibley has been appointed executive director of the Connecticut Hospital Association. A graduate of Harvard, Mr. Sibley was employed by the Security Trust Company of Rochester, N.Y., from 1931 to 1943. He left his position there as assistant trust officer to serve with the Office of Foreign Relief in the state department in Washington, transferring

Thermopane is readily available to increase insulating efficiency of your hospital

*Thermopane** in hospital windows helps provide indoor climate conditions most beneficial to patients.

This insulating windowpane minimizes condensation on glass, helping maintain proper room humidities. It reduces heat loss through glass as well as downdrafts at windows, assuring greater comfort in all parts of hospital wards. *Thermopane* even deadens outside noise, lessening disturbances for patients. It is, also, ideal for interior partitions, such as those enclosing nurseries.

Before you build or expand your existing plant, ask your architect about *Thermopane*—the insulating windowpane that makes large glass areas practical in all climates. It's made of two or more panes of glass separated by dehydrated air and factory-fabricated into a unit. L·O·F's *Bondermetic Seal** around the edges keeps dirt and moisture from entering the air space. *Thermopane* units can be installed in fixed or opening wood or metal sash.

L·O·F Glass Distributors can assure prompt delivery of *Thermopane* in over 60 standard sizes, as well as special sizes. For more information, write for our *Thermopane* book and Don Graf Technical Sheets. Libbey·Owens·Ford Glass Company, 3268 Nicholas Building, Toledo 3, Ohio. *®

879 *Thermopane* units in the Dr. A. J. Russo Clinic and residence, Salem, Va., provide insulation for all windows in this air-conditioned building. *Above—Thermopane* in large windows of sunroom makes it comfortable at all seasons.

ONLY LIBBEY·OWENS·FORD MAKES

Thermopane

LIBBEY·OWENS·FORD

a Great Name in GLASS

in January 1944 to U.N.R.R.A. During two years in Greece, where he served as administrative officer, his duties included the rehabilitation of hospitals and the organization of malaria control programs.

Deaths

Sister Mary Alfreda Schumuki, O.S.B., superintendent of the training school for nurses at St. Joseph's Hospital, Boonville, Mo., for the last twenty-five years, died recently following a brief illness.

Phyllis Albright Swearingen, superintendent of Community Hospital, Medford, Ore., died May 18 at the age of 47. Miss Swearingen was born in Centerville, Ia., and in 1923 was graduated from Cook County School of Nursing in Chicago, where she later took special courses in eye, nose and throat work, obstetrics and anesthesia. She became superintendent of Community Hospital in 1930.

Dr. Earl W. Williamson, assistant director of the American College of Surgeons, was found dead in his berth on a train as it neared Chicago, May 10. Dr. Williamson was returning to his home in Evanston, Ill., after surveying a hospital in Lincoln, Neb.

Roderic Wellman, a director of the legislative bureau of the United Hospital Fund since 1935, and attorney also for the Associated Hospital Service of New York, died last month as the result of injuries suffered in a fall at his summer home in Muttontown, L.I.

Dr. George Wilson Terry Mills, 67, superintendent of Creedmoor State Hospital, Queens Village, N.Y., for sixteen years prior to his retirement in 1943, died recently.

BOOKSHELF

PROBLEMS OF HOSPITAL ADMINISTRATION. *By Charles E. Prall. Chicago: Physicians Record Company, Pp.* 104.

The Joint Commission on Education of the American Hospital Association and the American College of Hospital Administrators sponsored the studies which are summarized and interpreted here by Dr. Prall, who is director of the commission.

The personal interview technic used in developing major problems confronting hospital administrators seems to have been an excellent one. Doctor Prall's clear explanations of the strengths and weaknesses of this technic give the reader an excellent base on which to evaluate the results of the study. Although many of us have long known what the major problems in hospital administration are, the way Doctor Prall has presented them is a real education.

I was sorry to see that such an important job as purchasing does not seem to get much consideration in the study. Doctor Prall, however, discusses this lack in his summary of strengths and weaknesses of his results. Those of us who have had long experience in hospital administration and, in addition, have had an opportunity to discuss hospital problems with hundreds of administrators, department heads, trustees, and staff doctors will certainly agree with a major part of Dr. Prall's findings.

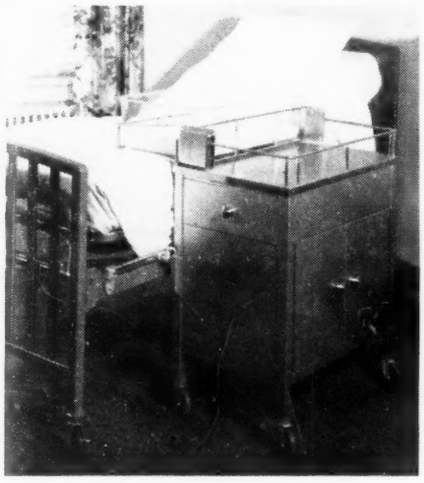
I believe that the results of the study as disclosed and summarized in this new book will be invaluable in helping to build and strengthen the curriculum in the several university courses in hospital administration. In addition, this report should be of great value in guiding those in charge of formulating institute and hospital convention programs. Dr. Prall has made a real contribution toward the betterment of hospital administration.—E. W. JONES.

What's New for Hospitals

JUNE 1948 SUPPLEMENT TO THE MODERN HOSPITAL

Individual Care Bassinet

A new bassinet designed especially for individual care of the infant at the



mother's bedside has an extension which allows the basket to be brought over the mother's bed and a special bracket to attach the bassinet stand to the mother's bed to prevent the stand from rolling out of easy reach.

The bassinet stand is of sturdy, all metal construction with large, easy-rolling casters so that it can be moved from a cubicle to the mother's bedside as required. The clear plastic basket rests in a metal frame so designed that it can be readily pulled out to facilitate care by the mother, without danger of tipping or pulling too far. The stand has full cabinet and drawer facilities for storing needed supplies for the care of the infant. A specially designed clamp, which is permanently attached to the mother's bed, permits the bassinet stand to be attached easily to the bed frame when the mother is to care for the infant and to be removed as simply when the bassinet is to be wheeled into a cubicle or other part of the room. The unit is especially effective when used with the Simmons self-adjusting bed and has been accepted as standard equipment in the maternity division of the new George Washington University Hostal, Washington, D.C. **Simmons Company, Dept. MH, 222 North Bank Drive, Chicago 24. (Key No. 4114)**

Improved SoundScriber

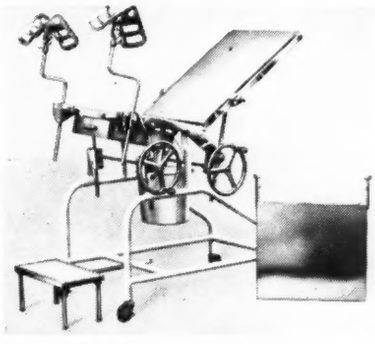
Series Four of the SoundScriber Electronic Disc Dictation Machine is the result of exhaustive research into the performance and actual use of the machine. The improved machine is available in the desk model finished in walnut with a built-in loud-speaker and a choice of either executive or hand microphone and the portable recorder finished in either leather or Fabrikoid with a choice of extension or hand microphone.

The transcriber can be used with the SoundScriber soft speaker, patented Toneband or stethoscope-type Monoset and has instantaneous start-stop and accurate backspacing. The units feature electromagnetic recording head, light beam indexer, dynamic speaker and the telephone recording feature for making an accurate record of important telephone conversations.

The three disc operation on the new machines permits recording of dictation, telephone conversations or memoranda with a quick switch from one disc to the other. The new "Secretary Arm" permits editing of material already dictated. **The SoundScriber Corp., Dept. MH, 146 Munson St., New Haven 4, Conn. (Key No. 4115)**

Improved Urological Table

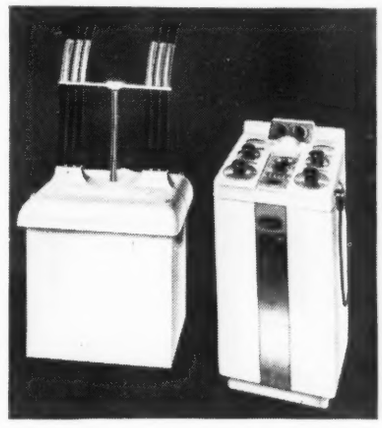
The S-1548-B Morgan Urological Table has been redesigned for greater efficiency and patient comfort. Improvements include concave seat cast of stainproofed aluminum alloy with raised rim on all sides for satisfactory drainage; deep front cut-out to permit ample room for instrumentation; center slot draining into a large, deep stainless steel drainage drawer; leg



and back sections covered with stainless steel; removable leg section; cast aluminum footstep which slides easily out of the way and seat and back sections individually adjustable by convenient hand wheels. **Shampaine Co., Dept. MH, 1920 S. Jefferson Ave., St. Louis 4, Mo. (Key No. 4116)**

Keleket Multicron 300

The new Keleket Multicron 300 is designed for flexibility, convenience and accuracy in all x-ray work. The



control cabinet is modern in design with sloping panel for ease and accuracy in reading. Large, well proportioned control knobs facilitate operation and the arrangement affords quick and accurate settings for any technic desired. Many factors are automatically adjusted by the generator which saves time and avoids confusion and errors.

The cabinet top is hinged at the rear for convenient and quick servicing from the front and the hinged door in the back affords quick access to the inside. The base is recessed to provide ample toe room for the operator and the unit is finished in the new Kelekote light, hard surface. The new transformer produces adequate energy for any radiographic, fluoroscopic or therapeutic technic and it is shockproof, electrically safe and not affected by changes in temperature or humidity. **The Kelley-Koett Mfg. Co., Dept. MH, Covington, Ky. (Key No. 4117)**

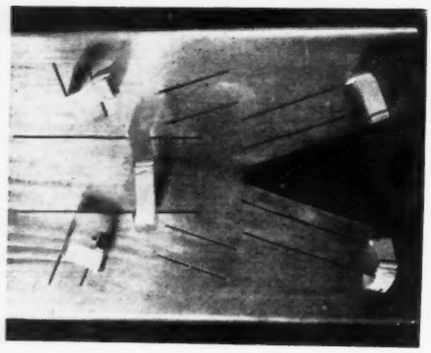
Bed Lamp

The Faries Manufacturing Company has announced a new bed lamp with a one piece heavy adjustable shade 8¾ by 4¼ by 3 inches which clamps to round or square horizontal bed rails. It is wired with a pull-chain socket and has a 9 foot rubber covered cord. The shade is electroplated satin chrome and the clamp is statuary bronze. It is especially suited for use on hospital beds. **Faries Manufacturing Company, Dept. MH, Decatur, Ill. (Key No. 4118)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 232

Immobilizing Board for Children

A new device for immobilizing children, from infancy to two years, for transfusions, intravenous and sub-



cutaneous injections and hypodermic therapy as well as for surgical procedures, has been announced under the name "Sta-Tot." Developed by surgeons to answer the need for an operating table small enough to handle infants, the Sta-Tot utilizes adjustable, pliable white web straps with buckles to immobilize the patient comfortably and conveniently. It can be sterilized and is placed on the standard operating or treatment table for infant patients.

Made of aluminated aluminum, the device is light and can be easily carried to the operating room or nursery. A towel or folded sheet can be used for padding and the unit is 18 by 30 inches in size. **The Gordon Gilbert Co., Dept. MH, 924 S. Lincoln, Spokane, Wash. (Key No. 4119)**

Air Diffuser

The Anemostat aspiration principle, which draws room air into the device and mixes it with supply air, is employed in the new type air diffuser recently released. Any desired air flow pattern ranging from draftless diffusion to downward projection, without affecting air resistance, may be obtained at the turn of a knob. Adjustment setting permits variation from 15 to 35 per cent of air drawn into the outlet.

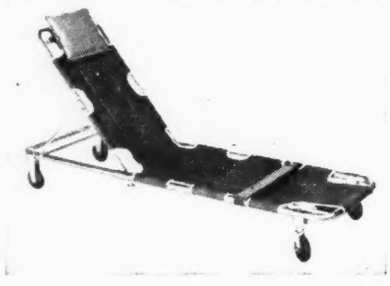
The new adjustable feature permits the Type C-1 Anemostat to be used for heating, ventilating or cooling in any combination. The air flow pattern may be modified to meet changing conditions and can easily be adjusted to neutralize the effect of local sources of heat gain or loss. It functions equally well mounted flush to the ceiling or on exposed duct work. Adjustment can also be accomplished by remote automatic or manual control. **Anemostat Corp. of America, Dept. MH, 10 E. 39th St., New York 16. (Key No. 4120)**

Excess-Smoke Indicator

The new Photoswitch Excess-Smoke Indicator, Type 2A10C, is designed to give a continuous indication to the boiler room of the condition of the gases which are passing through the flue, signaling when either smoke or air is sufficiently excessive to cause inefficient combustion or create a smoke nuisance. The equipment includes photoelectric control and light source mounted on opposite sides of the flue or breaching which indicate combustion conditions on a Densometer. **Photoswitch, Inc., Dept. MH, 77 Broadway, Cambridge 42, Mass. (Key No. 4121)**

Emergency Cot

The Collapsi-Cot is a new type litter which can be quickly converted to serve as a flat stretcher, transfer chair, convalescent lounge and for other emergency uses. The adjustable back-rest permits the back to be set at any desired position. The suspended hammock construction and elimina-



tion of spreader bars increase patient comfort and eliminate the necessity of using a mattress.

The Collapsi-Cot is easily set up, ruggedly constructed and is equipped with interchangeable crutch-tip uprights, waterproof pillow and two web restrainer straps with safety buckles. The cot is designed for use with ambulances. **Emergency Aids Co., Dept. MH, 2201 W. Winona St., Chicago 25. (Key No. 4122)**

Electronic Transcribing Machine

The new Electronic Transcribing Machine, Model "BE," is designed for perfect voice reproduction and has features which permit fast, easy, accurate transcription. The feather-light headset weighs only 1.2 ounces. It is the chin type which permits freedom of head movement and affords no opportunity of mussing the operator's hair. The "BE" is built to operate either with the headset or with a "soft speaker" if conditions permit.

The electronic controls on the new model make voices loud or soft, fast or slow. Three dials permit adjusting for volume, speed and tone. The red arrow automatically matches dictation on the cylinder with marks on the indication slip. Any dictation can be readily repeated by pressing the improved foot control backspacer or the manual auxiliary. The machine is available in two cabinet models as well as the desk set. **Dictaphone Corporation, Dept. MH, 420 Lexington Ave., New York 17. (Key No. 4123)**

Economist Steam Generator

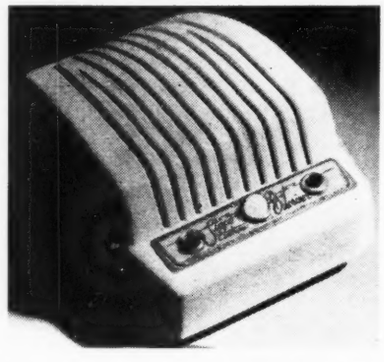
The Dutton Economist Steam Generator is designed to burn solid fuels, oil or gas with equal efficiency. The newly designed boiler provides for dual firing so that in case of shortage of one type fuel, it can be converted from oil or gas to hand or stoker firing or vice versa. The change can be accomplished without affecting the efficiency of operation.

The new unit is a highly efficient steam generator engineered to operate with light oil, heavy oil or gas, and for firing solid fuel by either hand or stoker. It is an automatic package type steam generator with full length refractory lined fire box and is shipped completely bricked up and insulated, ready for use. **The C. H. Dutton Co., Dept. MH, Kalamazoo, Mich.** Key No. 4124)

Electronic De-Odorizer

The new Staco Electronic De-Odorizer is a small, attractive unit designed to purify the air while removing objectionable odors. It is light in weight, can be hung on the wall or placed on floor or table and operates by merely being plugged into the ordinary electric outlet.

This scientific electronic unit requires no oiling or other servicing. It may be used continuously or intermittently and a pilot light indicates when



the unit is operating. **Standard Electrical Products Co., Dept. MH, 400 Linden Ave., Dayton 3, Ohio. (Key No. 4125)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 232

Seamless Pro-Cap Adhesive Plaster

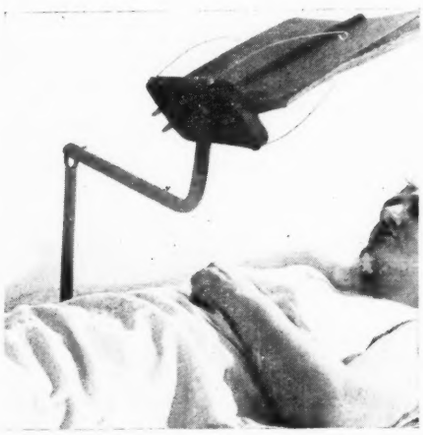
Zinc propionate and zinc caprylate have been incorporated into the formula for Seamless Pro-Cap Adhesive Plaster. The addition of small quantities of these two fatty acid salts is designed to reduce the possibility of irritation when the plaster is left on for long periods or must be frequently re-applied. Reports of tests of the use of the new plaster indicate that it adheres more firmly to the skin, does not curl at the edges and does not tend to slip. **The Seamless Rubber Co., Dept. MH, New Haven 3, Conn. (Key No. 4126)**

Hair Dryer

A new Perc Westmore professional type hair dryer which has been designed for home use should be of interest to those in the hospital responsible for patient care. When it is necessary to shampoo a patient's hair, this new portable, all-aluminum, light weight hair dryer should be helpful. A standing type unit, the dryer is economical to operate and can be easily set up. It is adjustable for height, instantly adjustable for position and has a lap switch so the patient can regulate the air. **Hollywood Industries, Inc., Dept. MH, 6235 S. Manhattan Place, Los Angeles 44, Calif. (Key No. 4127)**

Three Way Reading Stand

The Three Way Reading Stand is designed to hold books, magazines and newspapers in any position that may be required by the patient, either in bed, in a wheel chair or while convalescing. It operates on a ball and socket which makes it adaptable to almost any position, the pages being firmly clamped whether the reading



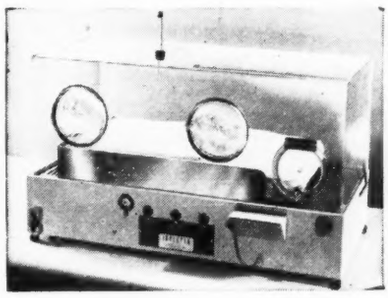
matter is held vertically, backwards, forwards or on the left or right sides.

The stand is adjusted by merely pushing it into the desired position and can be raised or lowered as much as five feet. The stand is light in weight, easily moved and is made of fine steel tubing for long wear. The stand is manufactured by Standard Metal Products Corp., Rochester, N. Y., and distributed by **Roy Ketchem, 1117 Grand Central Ave., Horseheads, N. Y. (Key No. 4128)**

Isolette Incubator

The Isolette is the name of the Chapple incubator and isolation unit which permits the care of normal and surgical patients as well as infants with infections, all in the same room. Filtered fresh outside air is circulated within the Isolette chamber which is kept constantly closed, thus eliminating exposure to droplet and air borne infection and minimizing the possibility of contact infection.

The transparent Plexiglas dome permits constant observation of the infant and plastic sleeves with elastic wristlets give access to the infant for feeding and other care. A service door in the dome is provided for admitting bottles, diapers and other supplies and when the door is open, the air flows out through it because of the slight



positive air pressure maintained within the closed chamber.

The Isolette provides complete control of temperature, humidity and oxygen concentration, a glass tube for the administration of parenteral fluids when necessary, constant prescribed environmental conditions and measures to ensure the safety of the mechanism. **Air-Shields, Inc., Dept. MH, Hatboro, Pa. (Key No. 4129)**

Skid-less Floor Enamel

The new Rubber-Coat Skid-less Floor Enamel is a 50 per cent rubber-based, one hour drying enamel. Designed especially for heavy traffic conditions found in hospitals and other institutions, the new enamel is resistant to accidental spillage of alcohol, gasoline and most chemicals, is skid resistant, resists wear due to cleaning and costs less than one cent per square foot. **The Wilbur & Williams Co., Dept. MH, Greenleaf and Leon Sts., Boston 15, Mass. (Key No. 4130)**

Posture Chair with Casters

A posture chair with all-welded construction and adjustable back rest, which can be easily moved by the occupant, has been developed by Everest & Jennings. The chair is equipped with four 5 inch casters with soft rubber tires. The caster wheels are ball-bearing with double ball-bearing caster swivels. Thus patients or personnel who are unable to stand but can use their feet and legs can use the chair while working in the occupational therapy department or other locations, or in exercise rooms, and can transport themselves without undue strain.

The chair should be of particular interest in hospitals for chronic diseases, Veterans Administration hospitals, hospitals for the crippled and similar institutions. **Everest & Jennings, Dept. MH, 7748 Santa Monica Blvd., Los Angeles 46, Calif. (Key No. 4131)**

Letheray Germicidal Unit

Stores of food and other supplies kept in storerooms can be protected from airborne bacteria and mold spores with the new Letheray germicidal unit. It is so designed that it can be placed in any position practicable for thorough irradiation. Swivel joints permit movement of the complete unit or parts of it to any position. The stem may be suspended vertically, with lamp horizontal or perpendicular, depending on conditions.

Letheray is equipped with a Hanovia cold cathode lamp and will operate at normal or freezing temperatures. The fixture is made of polished aluminum and the 12 foot aluminum cable makes it possible to install it just where it is needed. The unit can also be used to sanitize washrooms, rest rooms and lavatories as well as nurseries and other patient areas. **Hanovia Chemical & Mfg. Co., Dept. MH, Newark, N. J. (Key No. 4132)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 232

Wyandotte Skortex

Skortex is a new Wyandotte laundry product, a synthetic type detergent compound which has proved especially effective for soil removal from all fabrics, including cottons. Field tests on all types of fabrics resulted in exceptionally bright and clean work and wash wheels free of scale or discoloration. The new product is composed of an organic chemical "promoter," a synthetic detergent and an alkaline builder. **Wyandotte Chemicals Corp., Dept. MH, Wyandotte, Mich. (Key No. 4133)**

Unit Escalator

Hospitals with heavy out-patient loads where the department is on more than one floor will be interested in the new Escalator engineered by Otis Elevator Company. A self-contained unit of vertical transportation equipment, the operating machinery is built within the Escalator, thus eliminating the need for a separate machine room. This is possible because the new model is designed for a maximum rise of 23 feet, thus making it possible to build a safe, efficient unit with lighter weight structural and mechanical members.

The Escalator has a width of 32 inches between handrails and can handle 5000 persons per hour if required. The design changes cut installation costs, reduce power consumption and permit a lower purchase price without sacrifice of safety devices or operating efficiency. **Otis Elevator Co., Dept. MH, 260 Eleventh Ave., New York 1. (Key No. 4134)**

"Breathing" Mattress

The new Life-Long "12" Hard "Breathing" Mattress has been especially designed to meet hospital requirements for strength and firm support as well as long wear and patient comfort. The innerspring coil construction of heavy gauge, tempered wire, flexible border and cross-support coils and smooth, Jiffy tufts with wide tape contribute to wear and comfort. The mattress is ventilated with 378 small eyelets, permitting circulation of air within the construction and giving it the name, "Breathing" Mattress. This feature is also designed to further sanitation.

Other features of the new mattress include high grade felt used over sisal pads, flexible plastic handles for ease of handling, and a choice of two tickings — blue and white ACA, or tan and blue 2 inch striped 8 oz. sateen. The Life-Long mattress is 36 inches wide and 76 inches long. **Hard Mfg. Co., Dept. MH, 117 Tonawanda St., Buffalo 7, N. Y. (Key No. 4135)**

Pharmaceuticals

Crysticillin

Crysticillin is a new type of prolonged action penicillin for aqueous injection which contains no oil, wax or vasoconstrictors, yet produces therapeutic blood levels for 24 hours in the majority of patients (and for 36 hours in many patients) through the administration of a single 1 cc. 300,000 unit injection. The prolonged concentration of penicillin in the blood results from the low water solubility of the procaine penicillin G.

Crysticillin needs no refrigeration and is supplied in diaphragm-capped vials containing 1,500,000 units of procaine penicillin G and a small quantity of effective and nontoxic dispersing and stabilizing agents. **E. R. Squibb & Sons, Dept. MH, 745 Fifth Ave., New York 22. (Key No. 4136)**

Micropellets Progynon

Micropellets Progynon are pure micro crystals of alpha estradiol for intramuscular injection when suspended in normal saline solution. The water is absorbed and the Micropellets remain in the tissue, thus providing an immediate and prolonged effect. **Schering Corp., Dept. MH, Bloomfield, N. J. (Key No. 4137)**

Streptomycin, S & D

A highly purified, improved form of Streptomycin offering uniform potency, minimal pain on injection and decreased toxicity has been announced by Sharp & Dohme. The new antibiotic is supplied in 20 cc vials, each vial containing 1.0 Gm. of streptomycin base. **Sharp & Dohme, Inc., Dept. MH, Philadelphia 1, Pa. (Key No. 4138)**

Cellothyl

Cellothyl is a bulk laxative in tablet form for the treatment of functional constipation. Cellothyl passes through the small intestine as an inert liquid and forms a gel upon reaching the colon. It is easily administered in precise dosage and is designed for more physiologic action. It is supplied in bottles of 50, 100 and 500 tablets. **The Maltine Company, Dept. M, 745 Fifth Ave., New York 22. (Key No. 4139)**

Syrup Hycodan Bitartrate

Hycodan Bitartrate, the sedative anti-tussive supplied in tablet and powder form, is now available also as a syrup. It is indicated for all types of coughs. **Endo Products Inc., Dept. MH, Richmond Hill 18, N. Y. (Key No. 4140)**

Vytinic

Vytinic is a liquid hematinic with folic acid for the prevention and treatment of nutritional hypochromic anemias. Iron, liver, folic acid and the B complex factors are combined in a pleasantly flavored syrupy liquid which is supplied in 12 ounce bottles and in gallon containers. **Bristol Laboratories Inc., Dept. MH, Syracuse 1, N. Y. (Key No. 4141)**

Name Change

Alcohol in Vitadex-B is the new name for the prolonged analgesic with vitamin B which was formerly known as Alco-Dex. **Cutter Laboratories, Dept. MH, Berkeley 1, Calif. (Key No. 4142)**

Peptic Ulcer Treatment

Two products for treatment of peptic ulcer have been announced by Upjohn. Enterogastrone Hydrochloride, 200 mg., sterile, contains principles that have been demonstrated to inhibit gastric secretion and protect gastric and duodenal mucosa from ulcerations. It is supplied in a package containing 200 mg. enterogastrone hydrochloride in a 10 cc. vial and one 5 cc. ampule sterile water for intramuscular injection.

Malcotabs, half-strength, with Belladonna, for oral dosage, contain half the strength of Malcotabs, and are designed as a gastric antacid antispasmodic. They are supplied in bottles of 100, 500 and 1000. **The Upjohn Company, Dept. MH, Kalamazoo 99, Mich. (Key No. 4143)**

White's Mol-Iron Liquid

A new stable, palatable dosage form of molybdenized ferrous sulfate is offered in the new Mol-Iron Liquid. The product is designed for the treatment of hypochromic anemias in infants and children as well as in adults. It incorporates ferrous sulfate with molybdenum oxide in a pleasant tasting syrup form. It is supplied in 12 fluid ounce bottles. **White Laboratories, Inc., Dept. MH, Newark 7, N. J. (Key No. 4144)**

Rayopake

Rayopake is a new viscous contrast medium, water-soluble, for x-ray studies of the uterus, fallopian tubes, bladder and urethra. It is rapidly absorbed from serous or mucous surfaces and is readily miscible with urine, thus making aspiration unnecessary. It has high viscosity and gives excellent radiographic shadows. **Hoffmann-La Roche Inc., Dept. MH, Nutley, N. J. (Key No. 4145)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 232

Product Literature

• The revised edition of the booklet, **"A Suggested Standard Nursery Technique for the Routine Care of the Newborn in the Nursery,"** is now available from The Mennen Co., Newark 4, N. J. This manual for nursery procedures is divided into two parts, "Aseptic Nursery Routine" and "Cardinal Principles of Impetigo Control" and represents a consensus of methods followed to provide adequate prophylaxis and aseptic care for the newborn in the hospital nursery. **(Key No. 4146)**

• Users or prospective users of electric generating plants will want a copy of the new 16 page catalog, **"Electric Plants,"** issued by D. W. Onan and Sons Inc., Minneapolis 5, Minn. The catalog describes electric plant sizes ranging from 350 to 35,000 watts A.C. in all standard voltages, frequencies and phases, as well as direct current "direct service" type plants in 115 and 230 volt models. Battery charging plants are also described as are accessories for easier handling and better installation. **(Key No. 4147)**

• Detailed information on the **Prosperity Speedster Washer,** a 60 pound, all metal, Kleer Vision end door type machine, is presented in two leaflets issued by The Prosperity Company, Inc., Syracuse 1, N. Y. Describing the washer as combining two machines in one, Formatrol (automatic) operated, the folders stress the fast, thorough washing action that saves time, supplies, power and water. **(Key No. 4148)**

• A series of three catalogs covering extractors has been issued by Troy Laundry Machinery Division of American Machine and Metals, Inc., East Moline, Ill. These attractive folders give full construction details, installation and operating data and foundation plans on the **Troy Minute Man Laundry Extractors, Catalog No. YX-12-47, the Troy Atlas Laundry Extractors, Catalog No. YX-13-47 and the Troy Super-Mercury Laundry Extractors, Catalog No. YX-14-47. (Key No. 4149)**

• Information on the Kardex system of record keeping is given in an attractive folder issued by Remington Rand Inc., Systems Div., 315 Fourth Ave., New York 10, entitled **"Like Radar, Kardex Signals Exceptional Facts at a Glance." (Key No. 4150)**

• The **"Cory Service Policy"** covering their coffee brewing equipment is stated in a booklet issued by Cory Corporation, Coffee Brewer Div., 221 N. La Salle St., Chicago 1. **(Key No. 4151)**

• **"Dolophine (Methadon, Lilly), for the Relief of Pain"** is the subject of a booklet prepared by Eli Lilly & Co., Indianapolis 6, Ind. Indications, chemistry, tolerance and addiction and clinical use of this product, for oral or subcutaneous administration, in renal colic, surgical conditions, control of cough, obstetrics and non-surgical conditions are discussed. **(Key No. 4152)**

• Detailed information on **Adanon Hydrochloride,** the synthetic analgesic and antitussive, is given in a booklet issued by Winthrop-Stearns Co., Inc., 170 Varick St., New York 13. Pharmacology, clinical considerations, indications and dosage are some of the subjects covered. **(Key No. 4153)**

• The story of Minute Maid Orange Juice is told in a reprint entitled **"Orange Concentrate Frozen by Vacuum"** and issued by Vacuum Foods Corp., Park Square Bldg., Boston 16, Mass. The method of preparing this natural tasting frozen concentrate is described fully. **(Key No. 4154)**

• A catalog on **"The Scopicon,"** microviewing and projection apparatus, has been issued by Scopicon Inc., 215 E. 149th St., New York 51. Complete information is given on this interesting equipment, which can be used for projection of films, hood-viewing individually or in groups of the same specimen, consultation work, and for photomicrography. Tables and specifications are included as well as an index. **(Key No. 4155)**

• **The Vestal Specifications booklet, "Floor Facts,"** was designed by Vestal, Inc., 4963 Manchester St., St. Louis 10, Mo., especially for architects and engineers interested in better floor protection and maintenance. The booklet contains information about terrazo, asphalt tile, linoleum, rubber, concrete and wood floors, illustrating how materials should be specified. **(Key No. 4156)**

• The full line of rubber mats and matting manufactured by the B. F. Goodrich Co., Akron, Ohio, is illustrated and described in **Catalog Section 6100** issued by this company. Details of function, construction and specifications of each of the different types are covered in detail. **(Key No. 4157)**

• A chart listing the **"Ten Basic Rules for Foot Health"** has been issued by the Sole Leather Bureau of the Tanners' Council of America, 100 Gold St., New York 7. The information contained in the chart should be of particular interest to nurses and others who spend a large part of their time on their feet. **(Key No. 4158)**

• **"New Protection Against Damaged Walls"** is the subject of a leaflet issued by Hill-Rom Company, Inc., Batesville, Ind. Detailed information on Hill-Rom Cloth Covered Bumpers for dressers, beds, chairs, tables and other furniture which might otherwise mar walls and woodwork is given in the folder which should be of particular interest to the administrator and to the housekeeper. **(Key No. 4159)**

• A new color card containing color chips showing the full line of decorator colors available in the new one coat **Vita-Cal Self-Sealing Flat Wall Finish** has been released by the Vita-Var Corporation, Newark, N. J. Information on this new washable paint which covers almost all surfaces with one coat is included in the folder. **(Key No. 4160)**

Book Announcements

Appleton-Century-Crofts, Inc., 35 W. 32nd St., New York 1. Jordan, Harvey E., A.M., Ph.D., Sc.D., and Kindred, James E., M.A., Ph.D., "A Textbook of Embryology," 5th Ed., 627 pp., $7.50. **(Key No. 4161)**

McGraw-Hill Book Co., Inc., 330 W. 42nd St., New York 18. Dooley, Marion S., M.D., and Rappaport, Josephine, R.N., "Pharmacology and Therapeutics in Nursing," 460 pp., $3.75, and Neal, Raymond E., "Chemistry in Nursing," 400 pp., $4. **(Key No. 4162)**

The Macmillan Company, 60 Fifth Ave., New York 11. Walter, Carl W., A.B., M.D., "The Aseptic Treatment of Wounds," 366 pp., $9, and Menninger, William C., M.D., "Psychiatry in a Troubled World," 607 pp., $6. **(Key No. 4163)**

Oxford University Press, 114 Fifth Ave., New York 11. Allison, D. Rhodes, M.D., M.R.C.P., and Gordon, R. G., M.D., D.Sc., F.R.C.P., "Psychotherapy: Its Uses and Limitations," 168 pp., $3. Claye, Andrew M., M.D., F.R.C.S., F.R.C.O.G., "Management in Obstetrics," 188 pp., $4.25. Ryle, John A., M.A., M.D., F.R.C.P., "The Natural History of Disease," 2nd Ed., 498 pp., $7.50, and Wolff, Harold G., M.D., "Headache and Other Head Pain," 664 pp., $12. **(Key No. 4164)**

W. B. Saunders Company, W. Washington Square, Philadelphia 5. Dowling, Harry F., M.D., F.A.C.P., with Sweet, Lewis K., M.D., and Hirsh, Harold L., M.D., "The Acute Bacterial Diseases," 465 pp., $6.50. Goodale, Raymond H., B.S., M.D., "Nursing Pathology," 416 pp., $3. Manhattan Eye, Ear, Nose and Throat

Address manufacturers for further information and prices—or use Readers' Service blank on page 232

Hospital, "Nursing in Diseases of the Eye, Ear, Nose and Throat," 8th Ed., 309 pp., $3. Sands, Irving J., M.D., "Neuropsychiatry for Nurses," 5th Ed., 397 pp., $3. Sellew, Gladys, B.S., R.N., Ph.D., with Walters, Sister Annette, M.A., Ph.D., and Harvey, Sister Ann., B.S., M.A., "Nursing of Children," 6th Ed., 486 pp., $3.75. Todd, James Campbell, Ph.B., M.D., and Sanford, Arthur H., A.M., M.D., with Stilwell, George G., A.B., M.D., "Clinical Diagnosis by Laboratory Methods," 11th Ed., 954 pp., $7.50. **(Key No. 4165)**

Suppliers' Plant News

• **American Hospital Supply Corp., 2020 Ridge Ave., Evanston, Ill.,** serving hospitals of the country for the past 26 years, announces the opening of the new Southwestern Division at 2500 Commerce St., Dallas, Tex., to give quicker and more personal service to hospitals in the Southwest. **(Key No. 4166)**

• **Angelica Jacket Company, 1419 Olive St., St. Louis 3, Mo.,** manufacturer of washable service uniforms of all types, announces the opening of a new modern store at 1120 Walnut St., Philadelphia, to service small immediate needs of institutional customers in that territory. **(Key No. 4167)**

• **The Clay-Adams Co.,** manufacturer of hospital and medical supply items, announces removal from 44 E. 23rd St. to larger quarters at **141 E. 25th St., New York.** The company has also set up show and sales rooms at 308 W. Washington St., Chicago, for the convenience of customers in that area. **(Key No. 4168)**

• **Debs Hospital Supply Co.,** formerly at 205 W. Monroe St., Chicago, announces the removal of its headquarters to **118 S. Clinton St., Chicago 6.** **(Key No. 4169)**

• **North American Philips Co., Inc.,** manufacturer of x-ray equipment, announces the removal of its sales offices from 100 E. 42nd St., New York 17, to the new Philips factory and office building at **750 Fulton Ave., S., Mt. Vernon, N. Y. (Key No. 4170)**

• **Norton Lasier Company, 466 W. Superior St., Chicago 10,** announces a change in corporate name as of March 2, 1948, to **LCN Closers, Inc.** The company's ownership, management, location, products and policies remain unchanged. **(Key No. 4171)**

• **Pyrene Manufacturing Co., 560 Belmont Ave., Newark 8, N. J.,** has issued a notice recalling all extinguishers of the vaporizing liquid pump type of quart and 1½ quart size. An elusive and persistent corrosive in the extinguisher fluid, supplied to Pyrene by an outside manufacturer, has severely damaged some of the recalled extinguishers and the company therefore requests that all extinguishers of this type be returned for replacement. **(Key No. 4172)**

• **S. Blickman, Inc., Weehawken, N.J.,** manufacturer of the "Conqueror" line of stainless steel equipment, announces the appointment of John J. Egan Jr. as sales manager of the Hospital Equipment Division. **(Key No. 4173)**

• Mr. G. J. Dekker, recently elected president of **The Ohio Chemical & Mfg. Co., 1400 E. Washington Ave., Madison 10, Wis.,** announces the election by the board of directors of the company of L. L. Lunenschloss as vice-president in charge of hospital equipment sales; T. J. Rudesill, manager Scanlan-Morris sales; R. H. McElrath, manager Heidbrink sales; H. C. Hooper, manager gas sales, and T. H. Ricketts, manager suture sales. **(Key No. 4174)**

TO HELP YOU get information quickly on new products we have provided this convenient Readers' Service Form. Check the numbers of interest to you and mail the coupon to the address given below. If you wish other product information just list the items and we shall make every effort to supply it.

Bessie Covert,
Editor, "What's New for Hospitals"

- ☐ 4114 Individual Care Bassinet
- ☐ 4115 Improved SoundScriber
- ☐ 4116 Improved Urological Table
- ☐ 4117 Keleket Multicron 300
- ☐ 4118 Bed Lamp
- ☐ 4119 Immobilizing Board for Children
- ☐ 4120 Air Diffuser
- ☐ 4121 Excess-Smoke Indicator
- ☐ 4122 Collapsi-Cot
- ☐ 4123 Electronic Transcribing Machine
- ☐ 4124 Economist Steam Generator
- ☐ 4125 Electronic De-Odorizer
- ☐ 4126 Seamless Pro-Cap Adhesive Plaster
- ☐ 4127 Hair Dryer
- ☐ 4128 Three Way Reading Stand
- ☐ 4129 Isolette Incubator
- ☐ 4130 Skid-less Floor Enamel
- ☐ 4131 Posture Chair with Casters
- ☐ 4132 Letheray Germicidal Unit
- ☐ 4133 Wyandotte Skortex
- ☐ 4134 Unit Escalator
- ☐ 4135 "Breathing" Mattress
- ☐ 4136 Crysticillin
- ☐ 4137 Micropellets Progynon
- ☐ 4138 Streptomycin, S & D
- ☐ 4139 Cellothyl
- ☐ 4140 Syrup Hycodan Bitartrate
- ☐ 4141 Vytinic
- ☐ 4142 Name Change, Vitadex-B
- ☐ 4143 Peptic Ulcer Treatment
- ☐ 4144 White's Mol-Iron Liquid
- ☐ 4145 Rayopake
- ☐ 4146 "Nursery Technique"
- ☐ 4147 "Electric Plants"
- ☐ 4148 Prosperity Speedster Washer
- ☐ 4149 Troy Extractor Catalogs
- ☐ 4150 Kardex Leaflet
- ☐ 4151 "Cory Service Policy"
- ☐ 4152 "Dolophine"
- ☐ 4153 "Adanon Hydrochloride"
- ☐ 4154 "Orange Concentrate Frozen by Vacuum"
- ☐ 4155 Scopicon Booklet
- ☐ 4156 "Floor Facts"
- ☐ 4157 Catalog Section 6100
- ☐ 4158 "Ten Basic Rules for Foot Health"
- ☐ 4159 "Protection Against Damaged Walls"
- ☐ 4160 Color Card
- ☐ 4161 Books
- ☐ 4162 Books
- ☐ 4163 Books
- ☐ 4164 Books
- ☐ 4165 Books

I should also like to have information on the following products

_____

_____

NAME _____ **TITLE** _____

HOSPITAL _____

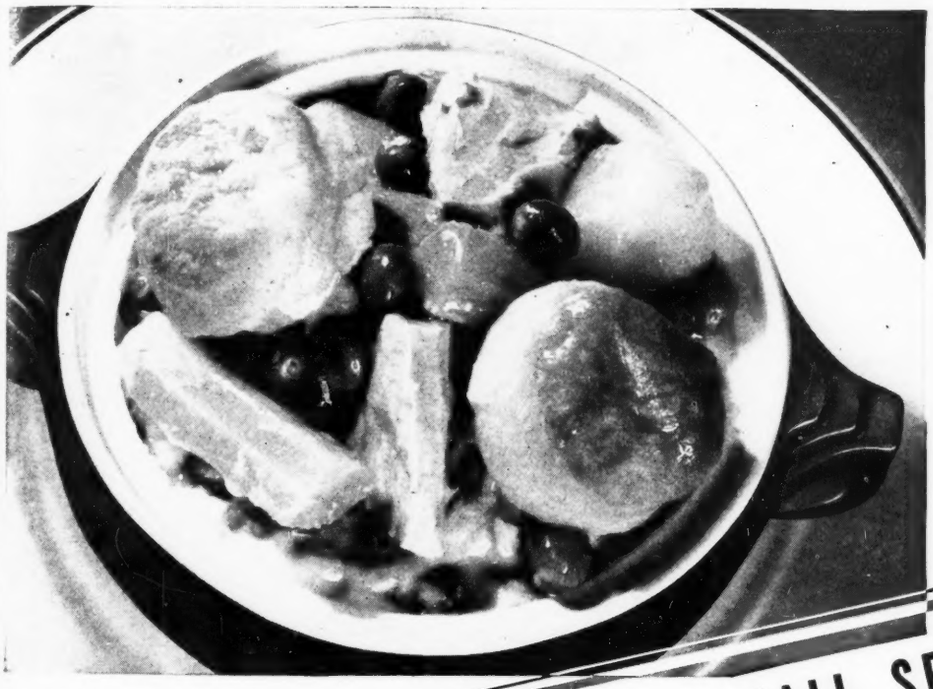
STREET _____

CITY _____ **STATE** _____

MAIL TO Readers' Service Dept., The Modern Hospital Publishing Co., Inc.

919 N. Michigan Ave., Chicago 11, Ill.

PRINTED IN U.S.A.



Delicious
TWIN CITY CHICKEN PIE

Named in honor of the two big cities where hearty appetites and appreciation for fine food go hand-in-hand, this nutritious chicken casserole recipe has all the requisites to arouse lagging appetites. Easy to prepare perfectly . . . by baking 10-15 minutes in a scientifically designed, fireproof Hall casserole. Easy to serve perfectly . . . for gleaming, crazeproof Hall China seals in pure flavor and holds the heat.

"New Recipes in **HALL SECRET PROCESS CHINA** *Relieve Menu Monotony and Aid in the Control of Food Costs"*

Extra Dividend for Hall China Users!

Hall baking dishes can be used for many purposes, other than the main course. For example . . . this eye and palate stimulating peach compote, browned in a Hall China sole dish, serves five persons at an extremely economical cost price. A tasty, healthful dessert, and it gives you an extra dividend on your investment in Hall China.

GOOD RECIPES BEGIN WITH

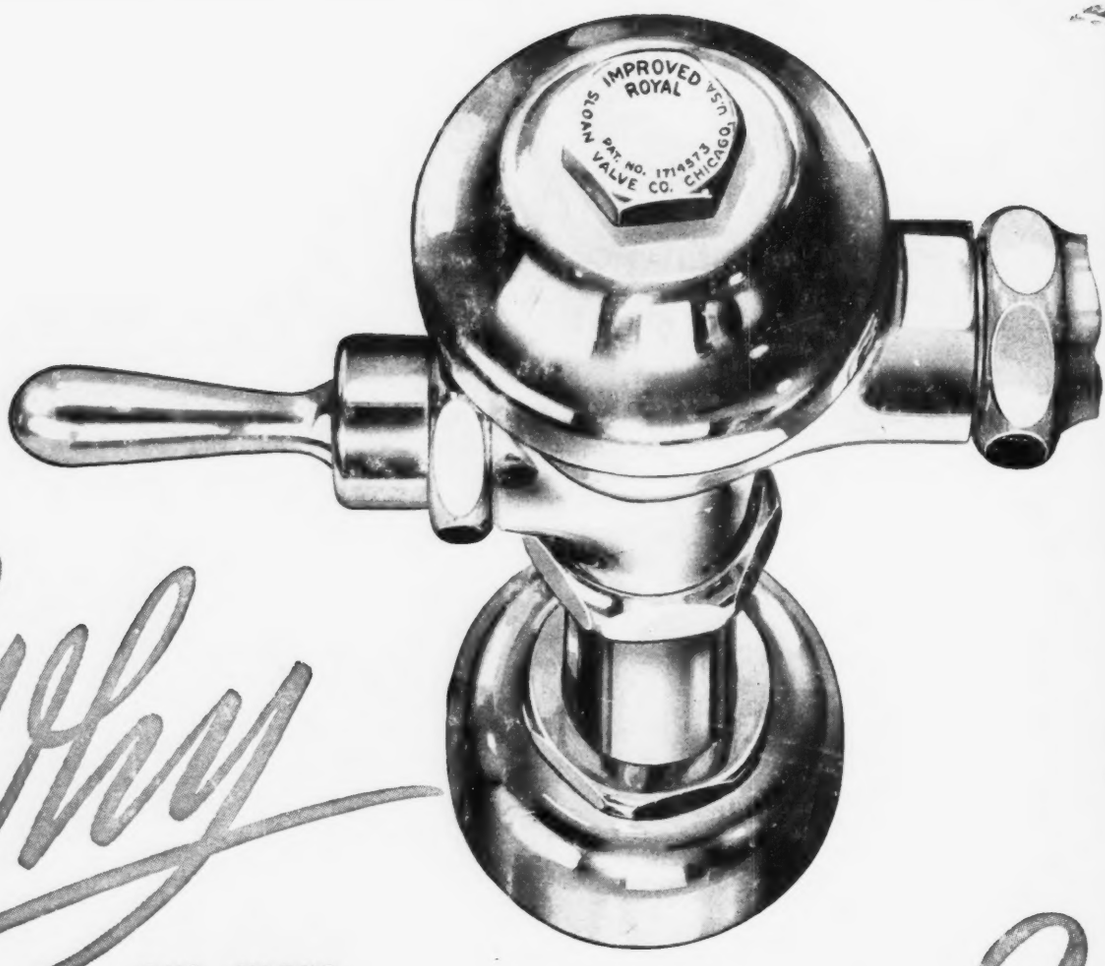
HALL

Secret Process

FIREPROOF CHINA

World's Largest Manufacturer of Fireproof Cooking China

THE HALL CHINA COMPANY · EAST LIVERPOOL, OHIO



Why are more SLOAN *Flush* VALVES sold than all other makes combined . . . ?

REPUTATION—Sloan is the world's largest manufacturer of Flush Valves exclusively.

ENDURANCE—Thousands of the first Sloan Flush Valves installed are still in perfect operation after 37 years of daily use.

LOW MAINTENANCE—Unequalled records show maintenance costs as low as ¼ of 1c per valve per year.

WATER CONSERVATION—Records prove that reduced water consumption has saved enough to pay for Sloan installations many times over.

SAFETY FROM POLLUTION—Sloan Vacuum Breakers absolutely prevent back syphonage —thereby protect public health.

QUIETNESS — Without screening the water, Sloan Quiet Flush Valves are whisper quiet.

PRICE — The plus values of Sloan's unequalled records of performance in the field are yours at costs no higher than others.

USERS GET MORE $ VALUE FROM

sloan *Flush* valves

4300 W. LAKE STREET CHICAGO · ILLINOIS